PERSONALITY DISORDER: A DIAGNOSIS FOR INCLUSION

THE NORTHERN IRELAND PERSONALITY DISORDER STRATEGY

JUNE 2010

FOREWORD

I am pleased to publish this strategy, 'Personality Disorder: A Diagnosis for Inclusion'. The very title emphasises the important direction we are moving, leaving behind the stigma and exclusion this diagnosis has attracted in the past, to now increasing our provision of specific evidence based treatments and promoting greater optimism for successful outcomes.

Generally a person is felt to have a personality disorder if their personal characteristics cause regular and long-term problems in the way they cope with life, interact with people and respond emotionally. Personality disorders are common, present in one person in twenty of the population, and for those people severely affected cause significant distress to the sufferer, their family and friends. Such distress may be evidenced by self harm, substance misuse, depression, eating disorders or other mental disorders, as well as childcare and social problems.

Given the profound impact that personality disorders have on individuals, families and communities, I am determined to enhance health and social care service provision. The Bamford Review recommended the development of dedicated services to meet the needs of people with a personality disorder, working across a range of settings. While the timescale for achieving the full Bamford vision is 10-15 years this Strategy, together with the additional dedicated investment I have secured, is an important step in ensuring that provision of regionally co-ordinated and dedicated services

Partnership working will be essential for the delivery of this strategy. In this regard, I am indebted to the Northern Ireland Office (now Department of Justice) and other agencies for their commitment to the development of this strategy.

I would also specifically like to highlight the key role that I feel service users and carers will play in the success of this strategy through their involvement in the development and evaluation of services, and also their provision of peer support and education, particularly promoting appropriate staff attitudes that will increase user engagement with services.

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EXECUTIVE SUMMARY

Personality Disorders (PD) are significant in terms of prevalence, subsequent morbidity and the challenge to a range of services presented by those with the most chaotic and disturbed behaviour. Unfortunately approximately 10% of people with a PD go on to complete suicide, while 12% of all people who complete suicide are considered to have a diagnosis of PD. It is generally acknowledged that personality disorders are caused by a combination and interaction of genetic vulnerability and adverse early experiences, such as abuse and neglect.

People with personality disorders are already heavy users of our health, social care and Criminal Justice services but currently are often not satisfied with how the traditional model of care provision addresses their needs and, in the absence of dedicated provision, may not receive the optimal care.

There is however established evidence that personality disorders can be effectively managed, increasing the person's quality of life and decreasing their use of health and criminal justice services, and Clinical Guidelines for the management of Borderline Personality Disorder and Antisocial Personality Disorder, developed by the National Institute for Health and Clinical Excellence (NICE), have been endorsed by the DHSSPS.

The Bamford Review of Mental Health and Learning Disability Services recommended the development of dedicated PD services in both the Forensic Services and Adult Mental Health Services reports. This led to a consultation exercise on the draft Northern Ireland Personality Disorder Strategy: A Diagnosis for Inclusion, which ended in March 2009 with a range of responses across health and social care organisations, the community and voluntary sector, individuals and Government.

This now final Strategy takes into consideration those consultation responses and sets out the overall way forward for developing services that will begin to address the complex range of needs of people with personality disorder. Such services should however seek to build on the existing skills and experience of local professionals, including those working within Probation and Prison services, and it is important in this context to recognise the professionals and organisations currently working with people with personality disorders that dedicated personality disorder services, as they develop, will work alongside.

The strategy has 17 recommendations:

Recommendation 1

> Services should be developed according to the principles outlined in this Personality Disorder Strategy.

Recommendation 2

As the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) commission personality disorder services they should, where appropriate, address particular client groups or specific needs. However, it will be for those responsible for implementation, to prioritise such developments and ensure a joined up multi-agency approach.

Recommendation 3

One Trust should lead the regional development of specific user and carer networks, including the provision of advocacy and a service element, which must sit within the other user/carer networks and arrangements as established by the Bamford HSC Taskforce and the Bamford Monitoring Group.

Recommendation 4

Initially services should be developed across tiers 0-3, working alongside and linking with existing health and social care and criminal justice services, and involving housing, employment and leisure agencies.

Recommendation 5

A specific prioritised role for those working in tier 3 services would be to minimise the need for transfer of people outside of Northern Ireland for treatment.

Recommendation 6

The options for a residential unit targeting adults with a personality disorder (particularly Clusters B and C), and with links to local mental health services, should be explored by the HSCB and PHA.

Recommendation 7

A dedicated Criminal Justice Residential Unit should be established to support the work of the new arrangements, Public Protection Teams, the Criminal Justice Order (NI) 2008 and sentencing framework. This would be the 'cornerstone' of a comprehensive new Outreach Service for offenders whose emotional and behavioural difficulties emanate primarily from personality based deficits and deficiencies.

Recommendation 8

In recognition of the high prevalence of personality disorder within prisons, and among those in contact with probation, the HSCB and PHA should develop as a priority, in partnership with Criminal Justice Agencies, services that address in a timely fashion the needs of such personality disordered individuals both within prisons and the community. Specific services should be developed within the prison establishments with multi-disciplinary skilled staff and where appropriate a residential component. Such services should address specific gender needs and be linked with both community services and also user and carer advocacy arrangements.

Recommendation 9

The HSCB and PHA should commission and develop a network of specialist personality disorder services, in co-operation with the single Trust delivering Tier 3 services and within available dedicated resources that capitalise on the existing skills and experience of local professionals in the management of personality disorders. This includes those working within Probation and Prison Services and building on Prison Service initiatives such as the Offender Management Model, the Resettlement Programme, the Safer Custody Strategy and the REACH unit in Maghaberry. (Further detail of these and other relevant initiatives are available from the Northern Ireland Prison Service)

Recommendation 10

The HSCB and PHA should, through the balance of investment in service development, ensure equality of access to specialist services is maximised. Specialist personality disorder services should work alongside and link with generic and other specialist mental health services including forensic mental health services and psychological therapy services, as outlined in the Psychological Therapy Services Strategy (2010).

Recommendation 11

Clear inter-agency working protocols, with integrated care pathways, should be agreed within the first year of services operating.

Recommendation 12

A joint regional training strategy should be implemented by the Trusts and Criminal Justice Agencies, following a training needs analysis, using the Knowledge and Understanding Framework and with meaningful user and carer involvement.

Recommendation 13

While supporting epidemiological needs, including the impact of the Troubles, the priority at this point is for the PD Network Group to feed in priorities into a research action plan for mental health and learning disability, as outlined in the Bamford Action Plan (2009-2011). This will promote knowledge transfer of research findings into practice and improve outcomes.

Recommendation 14

An interagency Personality Disorder Network Group should be established by the Health and Social Care Board and Public Health Agency to support implementation of the Personality Disorder Strategy. This should be part of the Bamford HSC Taskforce which will oversee implementation and review of the Bamford Action Plan (2009-2011).

Recommendation 15

The HSCB and PHA, in conjunction with the Personality Disorder Network Group, should develop the expected outcomes for services to deliver and specific proposals for service evaluation.

Recommendation 16

An overall review of the Strategy should be carried out, depending on progress with implementation, no later than five years from initiation.

Recommendation 17

As PD service development progresses, links should be made with other mental health service developments and initiatives through the Bamford HSC Taskforce.

2.0 BACKGROUND

2.1 Definitions

A definition of personality disorder is given in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1994) 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 childhood, is stable over time and leads to distress or impairment.

The World Health Organisation (1992) in their Classification of Mental and Behavioural Disorders describe personality disorders as follows:

These types of condition comprise deeply engrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in the giving culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance.

A useful way to consider the different types of personality disorder is to place them into 3 groups or clusters which bear similar characteristics.

Cluster A- 'Odd or eccentric' types (paranoid, schizoid, schizotypal)

Cluster B – 'dramatic, emotional or erratic' types (borderline or emotionally unstable, histrionic, narcissistic, anti-social)

Cluster C – 'anxious and fearful' types (obsessive/compulsive, dependent, avoidant)

Cluster C are the commonest in the community and primary care setting. However it is Cluster B, in particular Anti-Social Personality Disorder (callous, irresponsible, low frustration tolerance, lack of remorse) and Borderline Personality Disorder (unstable and intense emotional relationships, impulsivity, identity crisis, suicidal thinking and self harm, transient psychotic symptoms) that provide the greatest challenge within Health and Social Care and Criminal Justice settings because of the stress these disorders cause to the person, their family and society.

2.2 Estimated Prevalence

Population Studied	Prevalence of PD
Community	5%-11%
Primary Care Attenders	10%-30%
Psychiatric Outpatients	30%-40%
Psychiatric Inpatients	36%-67%
Prisoners	60%-80%

Due to differences in methodology, sample populations and potentially real differences across geographical locations, studies vary in relation to the reported prevalence of personality disorder. In the community figures between 4 and 13% are generally quoted. However, the Psychiatric Morbidity Survey (Great Britain 2000) did measure the prevalence of personality disorders in GB and an analysis of the data collected reported in 2006 a community prevalence of 4.4%.

Most personality disorders occur in those aged 25-44 years, and with equal prevalence across genders, although some disorders are much more common in specific genders, e.g. anti-social personality disorder is 5-6 times more common in men than women.

Within the community personality disordered individuals are more likely to experience adverse life events such as relationship difficulties, housing problems, long-term unemployment and also to suffer from alcohol and drug problems and offending behaviour. Importantly, approximately 10% of PD patients complete suicide, and 12% of all people who complete suicide have a diagnosis of personality disorder.

As shown in the table above personality disorders are not only common among the general public but prevalence increases markedly in specific populations. In the primary care setting studies report the prevalence of personality disorder as between 10 and 30%, with General Practitioners (GPs) most often encountering anxious, dependent and obsessive/compulsive disorders which can contribute significantly to their overall workload.

In mental health services personality disorders are extremely common additional conditions and affect the presentation and treatment of mental illness in about 30-40% of outpatients and approximately 50% of inpatients. Significantly, the presence of personality disorders is linked to poor outcomes for the treatment of the associated mental illness, increased risk of both deliberate self harm and completed suicide, and repeated unprofitable readmissions to hospital (so-called “revolving door syndrome”).

In the prison population large surveys have found the prevalence of personality disorders to be between 60 and 80%. Unsurprisingly anti-social personality disorder has the highest prevalence with estimates of 63% among male remand prisoners, 49% of male sentenced prisoners and 31% of female prisoners. Although women make up a very small proportion of prisoners it has been reported that proportionately more women than men commit suicide in prison, unlike in the community, and five times more self harm.

2.3 Management

Traditionally, the concept of treatability has been invoked in relation to Personality Disorders and used to exclude patients not only from compulsory admission but also from other services. Adshead (2001) describes that in no other branch of medicine does treatable equate with curable.

However the principles of treatment of personality disorder are those of any other chronic condition – the condition may not always be eradicated but distress in impairment and functioning (disability) may be alleviated in some areas and associated conditions treated.

Also, research suggests that treatment outcome, particularly for patients with borderline Personality Disorder, is much better than had previously been assumed, with over half showing clinical recovery.

It is generally accepted the best management approach for most mental disorders is through a bio-psychosocial model that holistically meets a person's needs. In personality disorder the therapeutic relationship is particularly important.

(a) Biological Management

In clinical practice medication is used as an adjunct to psychological and social approaches and, while there is no specific medication for personality disorder, nevertheless other medications have been shown to be effective in some personality disorders. Anti-psychotic medication for example can reduce paranoid symptoms in Cluster A disorders, while anti-depressants can help with mood difficulties in Cluster B disorders and also reduce anxiety in Cluster C disorders. Medication is also effective in the management of co-morbid mental health disorders, such as depression or schizophrenia, and the management of symptoms at specific times of crisis.

In considering medication it is worth noting that people with a personality disorder tend to have higher rates of placebo response, side effects, withdrawal symptoms and poor compliance than other groups. The key element in the use of medication for this group of patients is the therapeutic relationship with the prescriber.

(b) **Psychological Management**

There are a variety of psychological interventions that can be effective in helping people with a personality disorder and these include counselling, dynamic psychotherapy, mentalisation, cognitive therapy and dialectical behaviour therapy. These interventions can be provided in an individual or a group basis.

However, what is essential is the context of treatment and the patient's engagement with it, and this requires thorough assessment by appropriately trained, consistent staff who are able to work in a flexible and responsive way to provide a coherent treatment to the user. This approach requires a sound understanding of specific dynamic issues and the opportunity to recognise the impact of the patient/client on the clinician and team.

Given that personality disorder is a long-term complex problem it follows that treatment also needs to be consistent and of long duration.

(c) **Social Management**

Successful engagement in therapeutic work is more likely if basic social needs are catered for (Maslow's Hierarchy of Need). However, people with a personality disorder often have a compromised ability to meet their own needs or access appropriate services. Practical issues to be addressed include housing, finance, availability of services locally and transport to and from appointments. Consideration must also be given to the needs of carers and dependents.

There needs to be an emphasis on a readily accessible, socially inclusive and seamless integration of social and other services to avoid the repetition of previous adverse experiences for the person. Repeated "setbacks" may actually worsen the user's prognosis.

For example, the ethos of the Therapeutic Community (TC) model (Appendix 2) has been applied in the treatment of personality disorder for a number of decades and there is evidence of its effectiveness. TCs provide intensive psychosocial intervention which may include a range of therapies but where the therapeutic environment itself is seen as the primary agent of change. In this approach members of the TC are given greater autonomy in planning and engaging in their treatment and have a significant role in the everyday running of the TC.

2.4 Specific Personality Disorders

There are 2 personality disorders that due to their prevalence and morbidity warrant specific attention, Borderline Personality Disorder (BPD) and Anti-Social Personality Disorder (ASPD), and for both of these disorders the National Institute for Health and Clinical Excellence (NICE) published Clinical Guidelines in January 2009.

2.4.1 Borderline Personality Disorder (BPD)

People with BPD (emotionally unstable personality disorder) have unstable inter-personal relationships, fluctuations in self image and mood, fears of abandonment and rejection, a strong tendency towards suicidal thinking and self harm and may have brief psychotic episodes. BPD is often co-morbid with depression, anxiety, eating disorders, post traumatic stress disorder, alcohol and drug misuse and bipolar disorder.

Less than 1% of people in the community have BPD, with women presenting to services more often than men. In 2006/07, of the people admitted with a diagnosis of personality disorder to local mental health hospitals, over 40% were given the diagnosis of BPD.

The NICE guidance has identified priorities for healthcare staff in the management of people with BPD. These include ensuring that sufferers are not excluded from services, partnership working with sufferers to develop their autonomy, the development of optimistic and trusting relationships and the careful management of endings and transitions between services. NICE recommend that community mental health services, using multidisciplinary care planning, should be responsible for the routine assessment, treatment and management of people with BPD. NICE also recommend that specialist personality disorder services should be developed with roles including the assessment and treatment of people with particularly complex needs and/or high levels of risk, the provision of consultative support to primary and secondary care services and development of systems for communication and information sharing.

Brief psychotherapeutic interventions (of less than 3 months duration) are not recommended by NICE for BPD. Medication is also not recommended for BPD, but can be used in the short-term at times of crisis or for co-morbid conditions.

2.4.2 Anti-Social Personality Disorder (ASPD)

People with ASPD (dissocial personality disorder) are characterised by callous unconcern for the feelings of others, disregard for social norms, rules or obligations, an inability to maintain relationships or experience guilt, and low thresholds for frustration and aggression. They often also blame others, or offer plausible rationalisations, for the behaviour that has brought them into conflict with society.

ASPD has major public health implications in terms of its association with drug abuse, suicide, early unnatural death, violent and sexual crime, unemployment, homelessness, and family violence.

In the community there is a lifetime prevalence of 2-3% for ASPD (similar to major mental illnesses such as schizophrenia and bipolar disorder). It is commoner in men, younger people, those of lower socioeconomic status, single individuals, the poorly educated and those living in urban areas. In

prisons in England and Wales, a survey in 1998 reported the prevalence of ASPD was 63% for male remand prisoners, 49% for sentenced prisoners and 31% for female prisoners (Singleton 1998).

The NICE guidance priorities for the management of people with ASPD include the development of optimistic and trusting relationships, the routine use of standardised assessment tools as part of structured clinical assessment, group based cognitive and behavioural interventions and the treatment of co-morbid disorders. Equally the preventative role of measures to tackle conduct problems in children are highlighted.

Crucial for the safe management of people with ASPD is multi-agency networking. NICE recommends establishing clear pathways, enabling effective communication among clinicians and organisations, so that the most effective multi-agency care is provided. Multi-agency networks should develop standards for the coordination of clinical pathways, monitor their effectiveness and provide training, specialist support and supervision for a range of staff.

3.0 SERVICE USER AND CARER EXPERIENCE

Compared to any other group using mental health and other support services, people with personality disorder and their carers probably experience the lowest level of satisfaction with what has been traditionally provided.

By definition, people with personality disorders find it difficult to successfully negotiate interpersonal relationships and maintain a stable mood and way of thinking. This, together with a tendency to act impulsively, makes their interactions with health and social care and other services problematic. Repeated poor experiences may actually worsen their outcomes.

In the "Learning the Lessons" review (2007), many service users attending community based personality disorder services in GB reported feeling rejected and dismissed by generic mental health services. They expressed the importance of flexibility and accessibility in any services provided, of having appropriately skilled and qualified staff, of planning the discharge from services after treatment, and the provision of good out of hours crisis support.

It is essential that the views of service users and carers, including adverse experiences, inform how future services, both specialist and general, develop. This principle is emphasised by the following extracts.

A Service User's Experience

'B' is a 54 year old woman whose first experience of mental health services was in 1995 when she was detained due to risk of self harm.

For 10 years I floundered in the mental health institutions and services. I stumbled from crisis to crisis. I was hospitalised numerous times for varied reasons and various periods of time. During this time all my relationships broke down. I had a period of homelessness during which I lived in homeless hostels and rough on the streets. I had trouble accessing housing and benefits and often had no money or food.

Unsupervised I was abusing medication. Taking enough to knock me out for a few days at a time and not having enough to last for the month. I was cutting at regular intervals. I kept a rope in the house. Self harm became a habit, an addiction. Self harm had, in a grotesque way, become a comfort to me… I was carving graffiti into my body.

'B' was referred to a pilot service tackling self-harm where she was diagnosed with Borderline Personality Disorder and following assessment initially offered a 6 week group therapy programme.

There were 8-10 people who had been diagnosed with BPD, and like myself varied other mental health problems. In this group BPD was explained and discussed. We were given information about the disorder. I felt I had some say, that I could approach my treatment with some semblance of control. A course of treatment was negotiated.

There were other broader benefits to services that came from this group.

Most of us had presented in crisis to A&E and our experiences had been less than helpful. We discussed this at length. As a result I volunteered as a service user to a service improvement programme for people who presented to A&E in crisis. Over time we grew more confident about A&E since we knew they were making an effort in improving their approach.

Out of hours (5pm to 9am and weekends) no services were available. We put together and networked community and volunteer services and after hours medical services and distributed phone numbers. A number of us, including myself, suffered acute episodes of our illness. I experienced more supportive management of my episode and did not need to go in to hospital.

B' then entered an 18 month group.

I was having less cutting episodes. Although suicide was still an option I was able to define this feeling and work my way through to life. They once even came out to my house and took a rope I had always kept at hand to end my life. It was such a big thing to hand over my means of suicide.

A Carer's Experience

Living and caring for someone with Borderline Personality Disorder requires every ounce of maternal love that you have.

'R' was referred by her GP to child and adolescent mental health services where weekly therapy, together with anti-depressant medication, was commenced. However, because of concerns for her physical health she required admission to a children's ward in a general hospital and then in order to access specialist eating disorder services 'R' had to go to St George's Hospital, London.

For the next 5 months I lived alone in the flat, visiting 'R' briefly between meal times, therapy and school. It was a very lonely existence and often the only people I spoke to were staff and 'R'. Every weekend her dad or one of her brothers travelled to help me manage when we had to bring her home to the flat. Often she did not want to see us, was distressed and despite her protestations was forced to leave the ward. She ran out into traffic in an attempt to get knocked down and jumped on to the underground train as the doors were closing, leaving us on the platform. We had to lock away all the sharp implements and drink from plastic glasses.

At this time we began to feel that there was something more wrong with 'R' than, dare I say it, only Anorexia. The family therapist vaguely suggested BPD, but insisted that this diagnosis could not be made in a patient who was under 18

Following return to Northern Ireland 'R' initially intermittently returned to access therapy in London, however 'R' deteriorated, abandoned her school subjects, began self harming, vomiting and reducing her food intake.

After each overdose and very unpleasant stay with the unsympathetic staff in hospital, she was sent home. By this time we were living on our nerves trying to keep 'R' safe and my own mental health was suffering.

Following one overdose 'R' was sectioned under the Mental Health Order and admitted to a general hospital where there was no specialist nursing staff. She was subsequently admitted to an adult and then a newly opened adolescent mental health unit, but only after we took legal action, as they claimed she was too difficult to manage.

We spent hours every day on the unit. When she self harmed we were contacted and often accompanied her, along with staff, to A&E. On these visits we encountered unsympathetic, seemingly uncaring and often rude staff. Local anaesthetic, before stapling, was refused, and she was told if she removed stitches again subsequent wounds would not be treated.

When 'R' became 18 to access specialist services she again went to England. The unit she went to operated on a therapeutic community model and she responded well to dialectical behavioural therapy. However after 8 months

she was sent home, with only one week's medication. She was then referred to the North Belfast Self Harm Team where some progress is being made. 'R' has now moved out of the family home however this is not without its ongoing stresses.

I worry when there has been no contact for a day or two and yet dread the phone ringing for fear of what news it may bring. The hardest thing to come to terms with is the permanency and long-term aspect of the illness. I also grieve for the life that my beautiful, clever, artistic daughter could and should have.

4.0 UK STRATEGIC CONTEXT

4.1 England and Wales.

The "National Service Framework for Mental Health", issued by the Department of Health (DH) in 1999, aimed to improve service provision for all people with severe mental illness, including people with personality disorder. Recognising the particular need of this marginalised group, the DH issued two specific documents regarding personality disorder, both published by the National Institute for Mental Health in England in 2003.

The first document, "Personality Disorder: No Longer a Diagnosis of Exclusion", sets policy implementation guidance for the development and provision, by Trusts, of services for people with personality disorder. The objectives of this guidance can be summarised as:

(a) To assist people with personality disorder, who experience significant distress or difficulty, to access appropriate clinical care and management from specialist mental health services;

(b) 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; and

(c) To establish necessary education and training to equip mental health practitioners to provide effective assessment and management.

To achieve these objectives the guidance recommended:

- Development of specialist multi-disciplinary personality disorder teams.
- Development of specialist day patient services.
- Development of expertise within forensic services.
- Development of a small number of national personality disorder centres.
- Development of new training opportunities.

The second document, "The Personality Disorder Capabilities Framework – Breaking the Cycle of Rejection", outlines the skills and capabilities required by practitioners to deliver good quality services within new dedicated personality disorder services, mainstream mental health services, primary care and also in the wide range of other agencies involved in treating and supporting people with personality disorders. The fundamental aim is to help create a workforce that has a better understanding of personality disorder, thus interrupting the cycle of rejection often experienced by people with personality disorders due to current negative attitudes and practices within many agencies. It was recognised that as implementation of this framework

occurred the understanding of what is required, and in particular how these capabilities may be applied by different professional groups or within specific services, would evolve and grow.

"Personality Disorder Capacity Plans (2005)", driven by the DH and Home Office, provided a national overview of developments, commented on common themes and recommended a series of actions to improve services . There are some key themes which emerge from these plans, including:

- recognition of the need for a robust and coherent conceptual model to support PD capacity plans and strategy;

- the importance of partnership approaches across the many agencies involved in providing support to people with PDs;

- the need to develop appropriate and robust commissioning arrangements for PD services;

- the importance of engaging with primary care to support an improved response for people with PDs;

- the essential role of mainstream mental health services in providing for people with PDs; and

- the importance of staff attitudes and skills within current mainstream services in ensuring appropriate provision for people with PDs.

There are also a number of important issues that are relatively neglected in these initial plans, including:

- most plans do not adequately consider needs and service provision models for people with PDs and substance misuse problems;

- few plans mention the needs of people with learning disabilities and PDs;

- the importance of service user participation is only briefly considered;

- few plans have provided a clear view of the workforce impacts of their proposals; and

- few plans have referred to the needs of children and young people with early indications of emerging PDs.

The emerging Knowledge and Understanding Framework (P 31) will provide appropriate awareness and training opportunities to underpin development of PD services. This is being developed by the Personality Disorder Institute at the University of Nottingham, in partnership with the Tavistock and Portman NHS Foundation Trust, Open University and Borderline UK.

The Government also recognised, following several high profile cases, the public risk associated with those people suffering from a severe personality

disorder and who present a significant danger to others. Subsequent to a joint Home Office/Department of Health consultation paper in 1999, there was a Government commitment to a Dangerous Severe Personality Disorder (DSPD) programme across England.

The overall purpose of this DSPD programme is to support the development and delivery of new services so that people who present a high risk of committing serious violent or sexual offences, as a result of severe personality disorder, can be managed and treated through the appropriate pathway of care. The services are being developed under a joint partnership between the Ministry of Justice and the Department of Health, with the Department of Health taking the lead in developing the pilot services below high security.

The various initiatives above aim to develop more coherent, integrated services that promote inclusion, and also to develop a clear programme for training that enhances the capability and skills of staff to work with personality disorder clients. Together they have informed the subsequent development of such services across England and Wales.

The Department of Health issued 'Recognising Complexity: Commissioning Guidance for Personality Disorder Services' in June 2009 to support commissioners and service providers to work collaboratively to address the needs of local populations with PD. There is a focus on partnership, leadership, cost effectiveness, outcomes, service user involvement and the quality and skills of staff. This best practice guidance aims to encourage recognition that PD can form part of a complex profile of need across many service user groups, and effective commissioning depends on recognising this complexity when considering the needs of vulnerable children at risk, offenders, people with substance misuse problems, women with complex needs, and others.

In response to 'The Bradley Report' (April 2009), which made recommendations regarding people with mental health problems or learning disabilities in the Criminal Justice System, the Government issued a National Delivery Plan (Nov 2009) 'Improving Health, Supporting Justice' which aims to drive forward improvements in health and social care services for offenders and build on existing good practice. A key objective is the improved partnership working between criminal justice, health and social care organisations at all levels.

4.2 Scotland

The Scottish Government's 2003 publication 'Mind the Gaps' recognised that their personality service provision was "rudimentary, despite a growing evidence base for effective practice, intervention/management" and recommended the provision of adequate and integrated care for those with personality disorder.

In the Scottish Government's 2005 "Delivering for Health", and later reinforced in their 2006 "Delivering for Mental Health", there was a commitment that NHS

Quality Improvement Scotland (QIS) would develop standards for Integrated Care Pathways (ICPs). The QIS is a special Health Board which works with provider organisations to promote improvement in the quality of healthcare for the people of Scotland. These ICPs aim to be both generic for all patients accessing secondary care mental health services and also condition specific for schizophrenia, bi-polar disorder, depression, dementia and personality disorder. QIS produce these standards for ICPs in Mental Health Services in 2007, including the one for borderline personality disorder in relation to medication. NHS Boards are charged with local implementation and are currently developing their local pathways that QIS will first accredit and then subsequently monitor. It should be noted the generic standards will be as important in improving the care provided as the one specific standard for BPD.

The Scottish Executive's Mental Health Division's document "Personality Disorder in Scotland – Demanding Patients or Deserving People?" led to the establishment of the Scottish Personality Disorder Network in 2006. This Network brings together people from different professional backgrounds, users and carers to share relevant information and learning, to promote contact with other relevant networks, NHS bodies and the Scottish Government, and to explore key issues including education, training, research, treatability, pathways of care and user and carer issues.

Scotland also has an established Forensic Network whose report in 2005 "Services for People with a Personality Disorder" recommended:

- personality disorder should not be a diagnosis of exclusion from forensic mental health services;
- improved assessment and evidence based management for people with personality;
- improved staff engagement and staff training programmes;
- development of community service pilots;
- development of inpatient initiatives; and
- development of prison based pilots.

4.3 Northern Ireland

The needs of people with a personality disorder and the paucity of local services have been highlighted in the Bamford Review, both in the Adult Mental Health and the Forensic Reports. The Government Response to Bamford *Delivering the Bamford Vision*, issued for consultation in June 2008, recognised the need to develop a range of services for people with a personality disorder, thus promoting access to effective evidence based interventions, and further recommended the development of a specific strategy. Following consultation, a cross departmental *Delivering the Bamford*

Vision – Action Plan (2009 – 2011) was issued in October 2009. A key action within this Plan was the development and implementation of coordinated personality disorder services.

The Northern Ireland Mental Health Service Framework, which aims to improve health and social care outcomes, reduce inequalities in health, social wellbeing and improve service access and delivery, is currently being developed. This Framework will include standards for personality disorder which have been developed in liaison with professionals working in both health and criminal justice settings.

Since 2006 the DHSSPS has also had a formal agreement with the National Institute for Health and Clinical Excellence (NICE) and the Institute's guidance is now to be applied, following local review regarding its applicability, to Northern Ireland. Two NICE Clinical Guidelines, on Borderline Personality Disorder and Anti-Social Personality Disorder, were published in January 2009. Following local determination and endorsement, these were issued as the standards our local Health and Social Care Services are expected to achieve over time, with their progress being monitored by the Regulation and Quality Improvement Authority.

To manage sexual and violent offenders, who pose a continuing risk to the public within Northern Ireland, new sentencing and multi-agency public protection arrangements (PPANI) have been introduced under the NI Criminal Justice Order 2008. These new arrangements will result in more indeterminate public protection sentences, and it is likely that a significant proportion of offenders subject to such indeterminate sentences, and who pose a risk of harm to the public, will have a personality disorder and will therefore require input from specialist services for their ongoing assessment and management.

The lead responsibility for prison healthcare within Northern Ireland transferred to the Department of Health, Social Services and Public Safety in April 2008, and the high prevalence of personality disorder within prisons will therefore lead to an increasing need for such specialist input both within custodial and community settings.

Importantly the Prison Service recognises that mental health issues are often a key factor in women's offending, and can have a profound impact on how they experience custody. Women coming into custody will often have experienced a range of problems, including, abuse, domestic violence, substance misuse, self harm or attempted suicide, dysfunctional relationships with partners and families, poor educational attainment, poverty and, more generally, a poor self-image and lack of confidence that leads to limited choices.

The Prison Service recognises that interventions, tailored to meet the specific needs of women should form part of a realistic, multi-disciplinary approach, and that there is a need to work towards creating a more therapeutic environment for the promotion of women's mental health. Draft Gender-

Specific Standards for working with women prisoners were launched for consultation by the Prison Service in July 2009. These draft standards help to underpin the proposals in relation to custody contained within the draft Strategy for the Management of Women Offenders, published in February 2009. Both documents recognise the prevalence of mental health issues and personality disorder within the women's prison population, and advocate a gender-specific approach.

The Prison Service has also introduced the Offender Management Model which seems to reflect some of the guiding principles of effective therapy for people with personality disorders. This model specifically addresses key issues, referring prisoners for support in relation to issues such as offending behaviour, addictions, learning and skills, employment and family links. It will help prepare prisoners for release or to be seen by the Parole Commissioners. Similarly the Progressive Regimes and Earned Privileges Scheme (PREPS), which was re-launched alongside the Offender Management Model in June 2009, operates as an incentive programme in each prison establishment. On committal prisoners will start on standard level regime and should be actively encouraged to progress to the enhanced level of the regime where additional privileges and activities are available.

Finally, the Northern Ireland Prison Service and Probation Board for Northern Ireland Resettlement Strategy was agreed and signed up to in June 2004 by a number of organisations from the Statutory and Voluntary Sector. The focus for all of the organisations was tackling offending through an agreed holistic prisoner/offender resettlement strategy.

5.0 GOOD PRACTICE INITIATIVES

In other parts of the UK there have been for some decades various statutory healthcare, criminal justice and independent services that accepted people with a personality disorder for a variety of treatments in varying settings. However a further range of dedicated personality disorder service pilot projects were commissioned in 2004 to develop innovative and evidence based approaches that would improve the quality of care of people with a personality disorder. These pilot services include:

- community based personality disorder services; and
- Dangerous and Severe Personality Disorder (DSPD) programmes for;
  - medium secure and community forensic criminal justice services, and
  - high secure NHS and prison service pilots.

5.1 Community Service Pilots

There are 11 pilot community services which serve different populations from metropolitan boroughs up to county districts covering over 2 million people. Services provide a diverse range of approaches with 10 of the 11 services targeting adults and one for young people aged 16 to 25 years.

Guide to key services provided by the 11 pilots

LEAD ORGANISATION/SERVICE	NAME OF SERVICE	MAIN INTERVENTION
Camden and Islington Mental and Social Care Trust	Camden and Islington Personality Disorder Initiative	Advice, support and training for adults with PD, and healthcare workers
North East London Mental Health Trust	Dual diagnosis assessment and response team (DDART)	Psychological therapies for adults with PD & substance misuse
South West London & St George's Mental Health NHS Trust	Service user network (SUN)	Peer support for adults with PD
Cambridgeshire and Peterborough Mental Health Partnership Trust	Cambridge & Peterborough Personality Disorder Network	Psychological therapies and consultation service
The Haven Partnership	The Haven	Support, advice, psychological therapies and crisis beds for adults with PD
Oxfordshire Mental	Thames Valley	Support, advice, &

LEAD ORGANISATION/SERVICE	NAME OF SERVICE	MAIN INTERVENTION
Healthcare NHS Trust	Initiative (TVI)	day-TCs for adults with PD
Nottinghamshire Healthcare NHS Trust	Nottingham Personality Disorder and Development Network	Support, advice, psychotherapy & day-TC for adults with PD
Coventry Primary Care Trust	The Olive Tree	Out-patient individual and group psychotherapy for adults with PD
North Cumbria Mental Health and Learning Disabilities NHS Trust	North Cumbria Itinerant Therapeutic Community	Support and advice, internet-based peer support & a day-TC for adults with PD
Leeds Mental Health Teaching NHS Trust	Leeds Personality Disorder Network	Care co-ordination, psychological therapies and advice for adults with PD
Youth Enquiry Service/ Plymouth Primary Care Trust	Icebreak	Information & counselling for adolescents with personality disturbance

Following consideration of these pilots, members of the working group undertook a visit to the Thames Valley Initiative (TVI). This initiative is one of the largest and provides a service, using a hub and spoke model, for a population of 2 million across rural and urban areas. The service uses various therapeutic approaches and aims to provide support and treatment as close as possible to the person's home.

The service model is guided by the democratic principles of social inclusion, recovery, assertive outreach and therapeutic community. There is extensive service user and carer involvement at all levels of planning and delivery and the service uses a 4 tier model (Appendix 3).

All 11 pilot services, including the TVI initiative, were evaluated and a detailed report, "Learning the Lessons", published in 2007. This report outlined the views of service users and carers, service providers, referrers and commissioners on dedicated personality disorder services and concluded that specialist services can deliver high quality care to a group of people who have been poorly served in the past. Key lessons emerging included:

- The need to improve the initial assessment process to ensure that people receive more support.
- The need to ensure optimal group sizes.
- The need for greater flexibility and consistency in rules and boundaries in groups.
- The value of providing choice and the range of interventions on offer to service users (e.g. individual therapy at sites where only group therapy or peer support would be on offer, and telephone contact or crisis support at sites where these are currently not available).
- The need for services to improve their capacity to respond to diversity: efforts should be made to make contact with young people, with people from black and minority communities and with men.
- The importance of providing more support for carers, including carers' groups.
- The importance of developing service user involvement in the services.
- The need for better childcare support and access to benefits and housing advice.

5.2 DSPD Programme

Many people already receiving services within high secure hospitals and prisons have personality disorders. The DSPD Programme aims to support the development and delivery of specific new services in order that people who present a high risk of committing serious violent or sexual offences as a result of a severe personality disorder can be managed appropriately.

Medium Secure and Community Services

Various NHS Trusts host pilot services to deliver the Government commitment of 75 medium secure and specialist hostel places, with specialist community teams in support. These services have developed working relationships with a wide range of partners, including local forensic and general mental health services, probation service, prison service, the high secure DSPD pilot units and voluntary sector service providers.

Local Organisation	Service
East London and City NHS Mental Health Trust	20 medium secure beds 8 residential places Community team
Northumberland, Tyne and Wear NHS Trust	16 medium secure beds Community team and access to hostel beds
South London and Maudsley Mental Health NHS Trust	16 medium secure beds 10 residential places and community team
Merseyside Probation Service and Mersey Care Mental Health NHS Trust	30 residential place Community Risk Assessment and Case Management Service (CRACMS)
Oxleas Mental Health NHS Trust	6 specialist hostel places and outreach team

Following consideration of these pilots, members of the Working Group visited the Merseyside pilot – a partnership between Mersey Care Mental Health NHS Trust and Merseyside Probation Service. This service is a Community Risk Assessment and Case Management Service, CRACMS, (see Appendix 4), aiming to provide management and treatment interventions for high risk men leaving either NHS or prison DSPD services or direct from normal prison pathways.

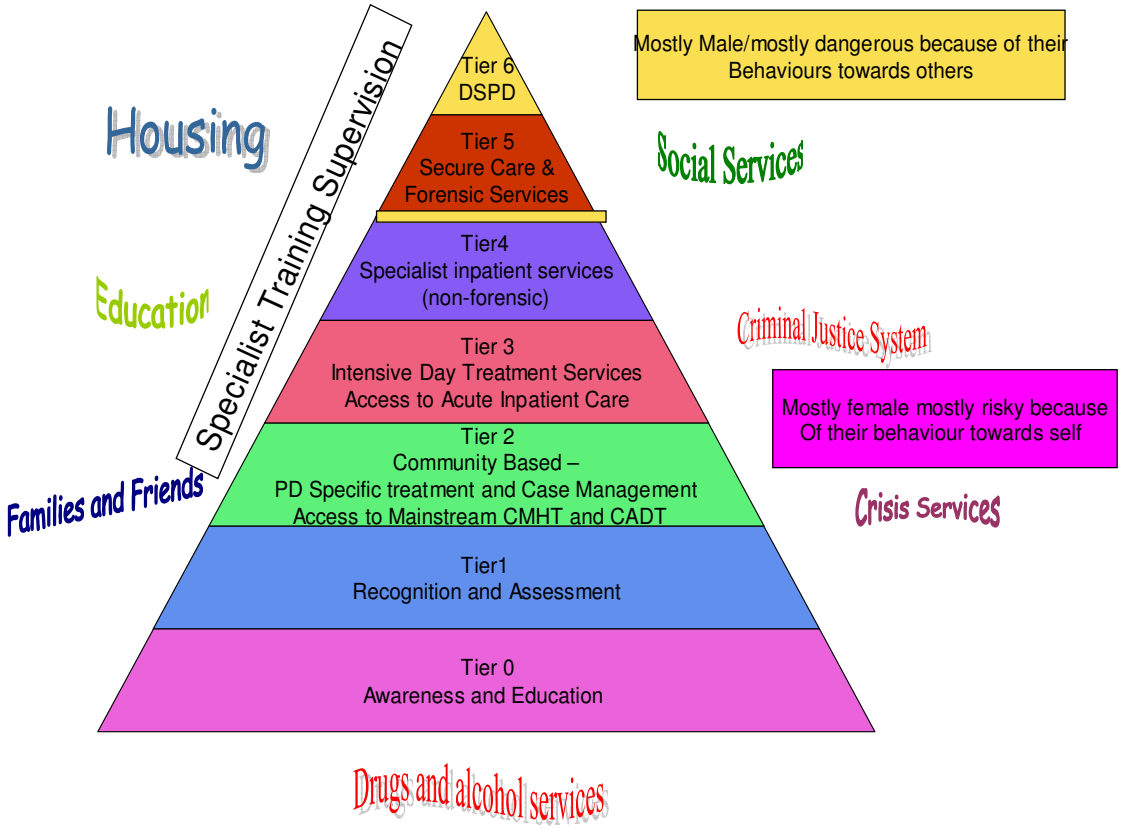
High Secure Services

Specialist DSPD high secure services for men have been developed in 2 prisons (HMP Whitemoor 70 places, HMP Frankland 86 places) and in 2 high secure hospitals (Broadmoor 70 places, Rampton 70 places). Pilot high secure services for women are being developed through a partnership between the prison service and Tees, Esk and Wear Valleys NHS Trust and are based at HMP Low Newton with 12 places.

6.0 SERVICE MODEL AND KEY ELEMENTS

6.1 Tiered Model

Personality Disorder services are often described using a tiered approach which allows service users to be appropriately directed according to their needs and complexity of their personality disorder and their capacity to engage with
services.



Structure for Tiered Personality Disorder Services Provision

Tier 0: General Education and Awareness

Tier 1: Recognition, Assessment, Engagement (Primary Care Services and Voluntary Sector).

Tier 2: Community Based PD Specific Treatments
Therapeutic Community
Community Case Management with PD Practitioners
Generic Mental Health Services
Access to mainstream community mental health services
Access to community addiction services

Tier 3: Intensive Day Treatment i.e. “Partial Hospitalization” Access to Acute Inpatient Care

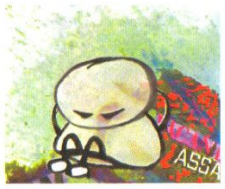
Tier 4: Specialist Inpatient Services (non criminal justice)

Tier 5: Secure Care and Criminal Justice Service

Tier 6: Dangerous and Severe Personality Disorder – access to medium and high secure facilities.

6.2 User Networks

Ex service users have been shown to provide key roles in many services. A good example where users (STARS-Support, Training and Recovery) and increasingly carers are involved at all levels in planning, designing and delivering services and in the teaching, training and recruitment of staff is the Thames Valley Initiative.



Who are STARS?
STARS are a team of ex-service users and experts by experience (ex-service users formally employed by TVI to work in groups). Most have been through therapy with the Complex Needs Service.

When and where do STARS meet?
Monthly, on the first Thursday of the month from 1.00 - 3.00pm, at The Friends Meeting House, St Giles, Oxford OX1 3LW

What happens at meetings?
Meetings start with a review of the last months' activities. Some months visitors come and talk about their work and find out what we do; some months there will be training opportunities; some months we discuss particular pertinent issues etc

What sort of 'work' do STARS do?
All sorts!! Roleplays, vignettes, question and answer sessions, attendance of meetings, and there's opportunities to help with clinical work too.

Who decides who does what ?
STARS members decide what they would like to, or feel able, to do from a list of requests for input. This happens at the monthly meetings. There is no pressure and new members are encouraged to 'tag along' with an 'old hand' to 'learn the ropes'.

What's in it for me?
There is payment available and travel expenses are covered. There may also be training opportunities for to take up.

Will this affect my benefits?
We are not experts on the benefit systems but believe that a variable amount can be earnt without affecting benefits, depending on the benefit being claimed. It is an individuals responsibility to check their own circumstances and earnings limits with the Benefits Agency.

What sorts of events have people been involved with?
Lead reviewer training with the Community of Communities; service user leadership course run by a local and national organisations; attendance at conferences in Cardiff, Belfast, Southampton, Athens; training courses in London and Carlisle and lots of local events in Berks, Bucks and Oxon etc
The Thames Valley Institute runs a year long course, Personality : People and Pathology in Oxford in which STARS members are an integral part. This course is for people from all a wide variety of areas both in the statutory and voluntary sectors.

What support is available?
Support is available by phone or from other members of the group - rather like the Complex Needs support system. Staff members from the Thames Valley Institute will also be at the meetings. Members also have a responsibility for their own health and well-being.

Service user networks are a key resource and the potential support available has also been shown elsewhere:

The North Cumbria ITC (Itinerant Therapeutic Community).

The Itinerant Therapeutic Community was launched in March 2005 as part of the National Development Programme for Services for People with Personality Disorder. It is an innovative service which develops and delivers treatment programmes for people with a diagnosis of Personality Disorder (PD) across North Cumbria.

The specialist multi-disciplinary team supports and treats people with moderate to severe personality disorders and through outreach has improved access to treatment across a huge catchment area. It has also allowed service users who had previously been unable to engage in treatment, or could not do so without unacceptable risks, to do so safely.

- **Innovation Corner: P2P :promote self-management and personal responsibility through user-led networks of out-of-hours care**

The ITC features P2P (peer to peer), a web-based initiative developed by service users and professionals in partnership with Xenzone Internet Technologies.

P2P is an exciting extension of an existing model, the user-led informal network of care pioneered at Winterbourne, a five day TC. One to one telephone support is replaced with a dedicated website with several levels of access ranging from a home page and magazine, through a message board, to on-line group conferencing in which service users can access peer support provided by three elected service users. The site is moderated by experts by experience (XBXs) and service user members of the ITC with a clear expectation that important events are reported at the next meeting of the community.

Equality of access is guaranteed by the provision of set top boxes which allow internet access for those service user members who do not have personal computers (a bonus is that free to view channels can also be accessed!).

While a key aim of the site is to provide out of hours interventions and support that aims to prevent service users entering into crisis, it also functions as a virtual rehearsal of the fundamental principles of TC work including personal responsibility and consideration for others.

6.3 Carer Networks

In the past 2 decades there has been an increase in awareness of the needs of Carers across the UK. However, there have been few initiatives to support Carers of people with Personality Disorder, despite evidence to suggest that enhanced family support can be beneficial to carers and can contribute to

better outcomes for users. In Northern Ireland, Carers of People with Personality Disorder report feeling isolated and, while there has been no regional investigation of carers' experiences, they are likely to be similar to those carried out in other areas of the UK. Again the Thames Valley Initiative provides a good practice example

6.4 Multidisciplinary Team Working

The preferred model for personality disorder services is a dedicated multidisciplinary team model where a group of specially trained practitioners work together, and whilst they may divide their roles, are all part of a specialist service. If good working relationships and close collaboration within the team are fostered, treatment is more likely to be consistent and implemented according to agreed protocols.

The multi-disciplinary approach of the dedicated team has advantages, particularly for patients with severe personality disorder who require frequent risk assessment, have multiple needs, demand continual engagement if they are to remain in treatment and provoke powerful counter-transference reactions. Such reactions of staff to patients with personality disorder commonly subvert the task of treatment and can lead to inappropriate actions on the part of staff. Therefore careful attention to counter-transference can reduce likelihood of unprofessional conduct, aid risk assessment and inform treatment intervention. The team approach dilutes counter-transference and offers a protection against any one individual becoming over-involved. In addition a team model offers the potential to implement comprehensive treatment plans in a constructive and clinically sensitive manner.

6.5 Access to Acute Psychiatric In-patient Support

One long standing belief amongst those involved in in-patient mental health hospital care is that people with personality disorders should be kept out of hospital. This is made on the basis that those with personality disorder exploit the opportunities offered by admission and, despite the fact that they do not really need to be in hospital, they create the circumstances whereby it is difficult to discharge them. However, people with personality disorders have fewer attachment and support figures in the community than others and few community teams can provide the level of support needed when their functioning begins to disintegrate. Unfortunately, few services have any desire to treat this group of difficult patients and the common reason for refusal, that they are "not suitable", should carry little weight.

Service Users are adamant that psychiatric inpatient care should only be considered when there are no safe alternatives - they comment on the poor physical environment of inpatient facilities, lack of privacy, the use of medication and detention, the stigma associated with admission and the lack of staff training and knowledge of providing for people with personality

disorder. However, there are occasions when in-patient admission is appropriate and indications for such acute in-patient treatment include:

- Crisis intervention, particularly to reduce risk of suicide or violence to others.
- Co-morbid psychiatric disorder, such as depression or psychotic episode.
- Chaotic behaviour endangering the patient and the treatment alliance.
- To stabilise medication.
- To review the diagnosis and treatment plan.
- Full risk assessment.

Clinical experience suggests that in-patient admission to a general psychiatric ward should be:

- Informal, with patient determined admission and discharge;
- Organised around specific goals agreed between patient, psychiatrist, nursing staff and others involved with the patient's care;
- Arranged with the clear agreement of nursing staff; and
- Brief, time limited and goal determined – user may be discharged if the goals of admission are not met.

6.6 Training Provision and Staff Skills

The behaviour of people with PD can often engender high levels of stress and helplessness amongst staff teams. Underpinning success in the development of any Personality Disorder Service is ongoing training and supervision. The Department of Health (DH, 2003) England publication "Breaking the cycle of Rejection: The Personality Disorder Capabilities Framework", sets out key skills and competencies for staff. This capabilities framework should be linked to the National PD Knowledge and Understanding Frameworks (KUFs).

The Personality Disorders Institute (Pdi), based at Nottingham University, is contracted by the Department of Health and Ministry of Justice to develop KUFs, in conjunction with partners Borderline UK, Open University and the Tavistock and Portman NHS Foundation Trust. The key purpose of the KUFs is to improve the quality of service user experience by developing practitioner attitudes, skills and behaviours. The KUFs are constructed to meet the needs of groups in criminal justice, health, independent and voluntary sectors, as well as service users and carers, and are available at different educational levels to meet the wide range of learning needs.

The materials now available and all the modules are designed to be delivered in both distance learning and classroom based formats through the Open University and franchised arrangements with local education providers.

Good Practice Example

The Thames Valley initiative (TVI) was developed between mental health trusts in Oxfordshire, Berkshire and Buckinghamshire, along with Grendon Prison and Broadmoor. The training team within this initiative provides a locally accessible training for PD practitioners. This is designed to be accessible to workers from all agencies and at all levels of education and competence.

Three levels of training have been identified: awareness, basic and specialist. These correspond to the 'training escalator' training stages in the DH Capabilities Framework.

'Horizontal reach' is required for **awareness**: so all staff having contact with people diagnosable with personality disorder are aware of the existence of the condition and the services available. This needs to be across all agencies, and across the geographical area served.

Basic training is suitable for any professionals whose day-to-day work involves substantial contact with PD.

Specialist training is for those who work, or who aspire to work, in PD services: the **'vertical reach'** describing pockets (or hubs) of specialist expertise and intensive treatment.

7.0 NORTHERN IRELAND POSITION

In Northern Ireland there are currently no dedicated personality disorder services. However, many people with a personality disorder present to local services where staff, within existing resources, respond to their various needs. Consequently local mental health and other services all have considerable experience in dealing with patients suffering from a personality disorder, although relatively few people are being treated explicitly for this.

For example in 2006/07 there were approximately 300 recorded admissions of people with a primary diagnosis of personality disorder to local mental health inpatient units, accounting for nearly 5,000 bed days. If those with personality disorder and another co-existing mental health diagnosis were taken into account, this rose to 400 admissions using over 7,500 bed days. The majority of such patients were between 25 and 45 years of age and there were 2 female patients to each male.

Community mental health services have reported that approximately 5% of their caseload present with personality disorders but can take up to 30% of team time, partly because of the complexity of their needs but also because of the pattern of their interaction and attachment styles with team members. Research also indicates psychiatric outpatients and those attending primary care also frequently suffer from a personality disorder.

People with personality disorder also represent a significant number of the more than 4500 people each year who need treatment at hospital due to self harming. Providing appropriate support can prevent an ongoing cycle of repeated self harm and the risk of suicide. The self harm service for North and West Belfast, providing follow-up to people attending A&E following an episode of self harm, found that over 80% of those with repeated self harm had a diagnosis of personality disorder. Through provision of ongoing treatment and support, particularly group interventions, there has been a marked reduction in self harming behaviour for this group of patients, including reducing their proportion of A&E attendances from 30 to 5%, fewer and shorter mental health inpatient admissions and greater engagement with education and employment.

In the community and voluntary sector many agencies provide a range of supports for people with personality disorders, from addressing practical issues, such as accommodation, through to therapeutic interventions. One local voluntary agency between 2002 and 2003 provided a specific initiative addressing personality disorder using a Therapeutic Community (TC) model. Even though this unit was only open for a short period of time there was indicative evidence of positive outcomes including that a decrease of self harm among the residents.

As already highlighted there is a high prevalence of PD among those people in contact with the Criminal Justice System. For example, within our local prison population, as across the UK, there is a high prevalence (60-80%) of

personality disorder which presents significant issues for the prison service, including challenging behaviour and self harm.

The REACH (Reaching prisoners through Engagement, Assessment, Collaborative working, Holistic approach) Unit within HMP Maghaberry was opened in April 2007. The REACH service was designed to identify prisoners with complex needs who are finding it difficult to cope in a prison environment and to provide assessment and support in a structured therapeutic environment with the aim of reintegrating prisoners into the wider prison population.

The Unit aims to improve the prisoner's mental health, social functioning and provide for improved prisoner/staff relationships through the concept of a meaningful day which is achieved through the use of structured participative activities.

The behaviours displayed by the inmates referred to REACH include:

- Risk taking behaviour.
- Deliberate self harm.
- A high rate of substance misuse.
- Prescription drug misuse.
- Difficulty relating to prison staff.
- Difficulty relating to other prisoners

In preparation for the REACH Unit opening a group of prison staff undertook a week of intensive training at the Whitemoor Dangerous and Severe Personality Disorder Unit in 2007, and a two week training course at NIPS College at Millisle. Additional training focusing on mental health issues such as self harm, suicide and ASIST has since been received by this group of staff through the Beeches Management Centre. Currently the unit is staffed by 14 discipline staff and 1.5 senior officers across a rotational shift basis, though initial proposals for this Unit envisaged Cognitive Behaviour Therapists (CBT), Occupational Therapy and Psychology input if the resource could be provided.

The REACH Unit provides accommodation for up to 18 prisoners in 14 single cells, 2 observation cells and a double listener cell. The service currently provides each prisoner with a person centred plan and a nominated key worker.

Another initiative by the NIPS that will benefit prisoners with a personality disorder is the revised Safer Custody Strategy, Supporting Prisoners at Risk (SPAR). It is casework focussed and introduces the role of SPAR Assessors and SPAR Case Managers. The key elements of SPAR are:

- Identifying those vulnerable people who are prone to self-injury or suicide.

- Immediately assessing their need.

- Putting a ‘safe plan’ in place right away.
- Using a Multi-Disciplinary Team (MDT) approach to develop a care plan to ease their distress.
- Reducing their isolation.
- Involving them fully in agreeing their Care Plan.

Finally, there is an increasing trend for some local people with personality disorder to require transfer to GB for specialist inpatient treatment which is not available within Northern Ireland. Since the type of service they require varies it is necessary to commission services for such patients in a range of specialist units in GB, including specialist medium secure units for personality disordered offenders, and in 2008/09 there were 15 people who received specialist treatment in GB at an overall cost of approximately £1.76M. With the development of local specialist services a key role will be provision of appropriate interventions to minimise such transfers.

8.0 PERSONALITY DISORDER SERVICE PROPOSALS

8.1 General Principles

The following are proposed as general principles for the development of services for people with a personality disorder in Northern Ireland:

- People with a personality disorder should have access to services that provide person centred and appropriate therapeutic interventions, taking account of the complexity of conditions, the holistic needs of the service user and available resources.
- Service users and their carers should be involved in a meaningful way in the planning and development of personality disorder services.
- Services should be safe for users, carers and staff.
- Services should be subject to ongoing evaluation of outcomes, with the involvement of service users and carers, and bench marked where possible against other comparable services.
- Services should be underpinned by effective communication and partnership working on a multidisciplinary, multiagency basis.
- Service users should be enabled to take control of, and responsibility for, their lives.
- Service users should be provided with choice in the interventions offered.
- Support should be available and planned for times of crises.
- Support should be provided for carers including carer groups.
- Staff should be appropriately trained, supervised and supported.
- Services should work within a recovery ethos.

Recommendation 1

Services should be developed according to the principles outlined in this Personality Disorder Strategy.

8.2 Comprehensive Services

People with personality disorders present differing challenges to various services across a wide range of settings. The development of comprehensive services to meet this spectrum of needs will involve a process of 'progressive realisation' of services over a long time period and this Strategy should be

viewed as a first step. Equally as this Strategy is implemented there should be ongoing recognition of the needs of specific groups, e.g. young people and women within the criminal justice system or people with a learning disability.

It is accepted that the Strategy is focusing on the development of services for those people with a personality disorder. However this does not detract from the importance of preventing where possible the actual development of personality disorders, an aim which aligns with a much broader spectrum of other strategies and initiatives, e.g. Investing for Health, Mental Health Promotion, Co-Operating to Safeguard Children, and links with ongoing developments in children's services and child and adolescent mental health services.

An Equality Impact Assessment was carried out (Appendix 5) and the DHSSPS considers that this strategy aims to impact positively on the health and wellbeing of people with a personality disorder and that it does not adversely impact on any of the Section 75 groups and therefore a full Equality Impact Assessment is not required.

Recommendation 2

As the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) commission personality disorder services they should, where appropriate, address particular client groups or specific needs. However it will be for those responsible for implementation, to prioritise such developments and ensure a joined up multi-agency approach.

8.3 User and Carer Networks

There is strong evidence for the benefits of user and carer involvement in all aspects of service development, planning, implementation and evaluation. To improve effectiveness such involvement should be co-ordinated with a single body responsible for developing user and carer networks.

Sufficient resources should be allocated to support these networks and advocacy services should be provided for users and carers in both the health and criminal justice systems. This approach should encourage service users to take responsibility for their own lives.

Recommendation 3

One Trust should lead the regional development of specific user and carer networks, including the provision of advocacy and a service element, which must sit within the other user/carer networks and arrangements as established by the Bamford HSC Taskforce and the Bamford Monitoring Group.

8.4 Tiered Model of Services

A well developed model for PD Services should be based on therapeutic services being available at all levels of care, delivered by well trained professionals and providing a pathway of care for individual service users. Such a tiered approach to service provision is in keeping with the future stepped care model being taken forward across our mental health services and should involve partnership working with user and carer groups and voluntary sector agencies.

As there are currently limited numbers of appropriately skilled staff available, and in order to maximise access to services for people with a personality disorder, it is proposed to initially develop services at Tiers 0-3 within NI. Where appropriate, these services should link to the stepped care model for development of generic mental health services, including psychological therapy services.

Tier 0:

Provision of general education and awareness will involve working across agencies to ensure that 'Basic' awareness of Personality Disorder – as recommended by the Capabilities Framework – is rolled out throughout the region**.**

Tiers 1 & 2:

Not all users with personality disorder require intensive specialized services and early interventions may be effective in preventing progression to a more serious condition. This requires additional resources to support greater role/input from community mental health services, voluntary agencies and primary care in the diagnosis and management of personality disorders. These tiers should promote expert user and carer involvement. As outlined earlier in this paper, people with Personality Disorder sometimes require access to acute general adult mental health in-patient units. This can be a time of great distress for the users and dedicated personality disorder services at Tier 2 should inreach to support the patient's care.

The residential therapeutic community is also a recognised effective model and, as already outlined, there is currently no such provision within Northern Ireland. Establishing such a unit would require co-operation across several agencies and this option should be explored as this Personality Disorder Strategy is implemented.

Tier 3

One Health and Social Care Trust should take the lead in establishing Tier 3 services. This will involve provision of an outpatient and intensive day patient service for complex and severe personality disorders and for those who have not responded to treatment within Tier 1 & 2 services. In consultation with other Trust areas, the Tier 3 service should lead and co-ordinate the

development of out of hours services for people with personality disorder that are locally deliverable.

To promote standardised best practice across N.I. the Tier 3 service should co-ordinate and lead the training and supervision of mental health care professionals and others, working at primary and secondary care levels, with the involvement of expert users and carers.

Tier 3 services should provide specialist input to Criminal Justice Services, including provision of high quality reports to support the Public Protection Arrangements Northern Ireland (PPANI) and in reach into prison establishments to support work with personality disordered offenders.

Another specific role for Tier 3 services would be to advise commissioners on the necessity for placements outside NI and contribute to monitoring the appropriateness of such placements and interventions. This gate keeping role would be carried out in partnership with CJS and forensic mental health services for those people requiring forensic secure placements.

As there are currently limited numbers of appropriately skilled staff available, and in order to maximise access to services for people with a personality disorder, it is proposed to initially develop services at Tiers 0-3.

Tier 4:
Specialist in-patient services

There is a debate about whether a local personality disorder service at this point could provide local inpatient specialist services (Tier 4). The experienced professionals required to establish and sustain such an in-patient unit are currently not available in Northern Ireland in sufficient numbers. In addition, the cost of a local specialist in-patient service would appear to be prohibitive both in absolute terms and in relation to its effect within current limited resources on other levels of the service (out/day patient, community-based and primary care).

Consideration should therefore be given to identifying assessment inpatient beds on acute wards staffed by generic mental health staff, with support by in-reach from dedicated community personality disorder services staff. This would allow for Complex and Severe PD patients, who might normally be hospitalised in an acute setting or transferred to Tier 4 services in England, to become engaged in Tiers 1-3 treatment and help facilitate care beyond this assessment, either in their own locality or in England. Tier 3 services should be involved in the decision for transfer to Tier 4 services and offer support to local services in facilitating the return from Tier 4 services.

Where such specialist in-patient Tier 4 services are unavoidable they should continue to be provided, as at present, from units located outside Northern Ireland and specific preferred providers should be identified to whom all such specialised referrals would be made. Extra contractual referrals to other

provider units would not be possible other than in exceptional circumstances. Apart from the probable savings resulting from a contractual approach, this would have the benefit of allowing consistent and sustained communication between the in-patient unit and local professionals regarding treatment following discharge. Additionally, local professionals could be seconded to the designated unit for short periods of time to enhance their skills in the management of personality disorders.

Criminal Justice System

An exploration of established services in England and Wales was undertaken to help determine the most appropriate model for services that would contribute to the provision of the safe and effective management of personality disordered offenders. Particular regard was paid to the comprehensive assessment of client psychopathology, and the construction of individualized and efficacious therapeutic interventions.

As a result the proposal is for a model similar to the Merseyside Probation Project referenced in this report (see Appendix 4). This facility is a Criminal Justice sponsored project and would appear to operate within parameters not dissimilar to Northern Ireland, particularly in terms of demand for services and the Criminal Justice legislative framework. The aim is to produce a pathway for offenders linking prison, a dedicated residential unit and other placements in the community. It is recognized, however, that progressing this dedicated residential unit is dependent upon both resources being secured from within the criminal justice system and the support of the Health and Social Care Services.

Since the outset in 2007 of the REACH service in HMP Maghaberry, there was recognition that specialist mental health input would be required to address the needs of prisoners referred to the service. It is considered with the addition of mental health nursing and broader skills such as occupational therapy and CBT/psychological therapies, the delivery of an enhanced programme of care and treatment can be provided. Through a pre-admission criteria assessment, ongoing treatment and associated care plan, leading to a managed discharge out of the Unit back into the general prison community, a higher volume of prisoners could be cared for with a greater level of effective interventions provided.

To achieve this enhanced service additional staff are required across a range of disciplines including nursing, psychiatry, OT and clinical/forensic psychology.

Recommendation 4

Initially services should be developed across tiers 0-3, working alongside and linking with existing health and social care and criminal justice services, and involving housing, employment and leisure agencies.

Recommendation 5

> A specific prioritised role for those working in tier 3 services would be to minimise the need for transfer of people outside of Northern Ireland for treatment.

Recommendation 6

> The options for a residential unit targeting adults with a personality disorder (particularly Clusters B and C), and with links to local mental health services, should be explored by the HSCB and PHA.

Recommendation 7

> A dedicated Criminal Justice Residential Unit should be established to support the work of the new arrangements, Public Protection Teams, the Criminal Justice Order (NI) 2008 and sentencing framework. This would be the 'cornerstone' of a comprehensive new Outreach Service for offenders whose emotional and behavioural difficulties emanate primarily from personality based deficits and deficiencies.

Recommendation 8

> In recognition of the high prevalence of personality disorder within prisons, and among those in contact with probation, the HSCB and PHA should develop as a priority, in partnership with Criminal Justice Agencies, services that address in a timely fashion the needs of such personality disordered individuals both within prisons and the community. Specific services should be developed within the prison establishments with multi-disciplinary skilled staff and where appropriate a residential component. Such services should address specific gender needs and be linked with both community services and also user and carer advocacy arrangements.

8.5 Service Organisation

Due to the specialist nature of dedicated personality disorder services, and the complexity of service user needs, it is proposed to deliver services through a managed network with a single regional centre in one Trust providing Tier 3 services in addition to the Tier 0-2 services that all Trusts will provide.

This Regional Network approach should balance the need for a centrally located resource, providing a critical mass of expertise, and services provided at a distance from this centre with locally based specialised staff who may have better communication with local professionals and voluntary agencies.

Such an approach aims to tackle the issue of ease of access for residents from all parts of Northern Ireland.

A Regional Network would also promote greater consistency of service provision and with development of clear protocols and integrated care pathways should improve transfer between, and communication across, service interfaces.

Recommendation 9

> The HSCB and PHA should commission and develop a network of specialist personality disorder services, in co-operation with the single Trust delivering Tier 3 services and within available dedicated resources, that capitalise on the existing skills and experience of local professionals in the management of personality disorders. This includes those working within Probation and Prison Services and building on Prison Service initiatives such as the Offender Management Model, the Resettlement Programme, the Safer Custody Strategy and the REACH unit in Maghaberry. (Further detail of these and other relevant initiatives are available from the Northern Ireland Prison Service)

Recommendation 10

> The HSCB and PHA should, through the balance of investment in service development, ensure equality of access to specialist services is maximised. Specialist personality disorder services should work alongside and link with generic and other specialist mental health services including forensic mental health services and psychological therapy services, as outlined in the Psychological Therapy Services Strategy (2009).

Recommendation 11

> Clear inter-agency working protocols, with integrated care pathways, should be agreed within the first year of services operating.

8.6 Training

There is broad support for joint training across health and social care services, criminal justice services and the independent sector. Training must address staff attitudes and this is an area where the involvement of service users and carers is invaluable.

A robust training programme in Northern Ireland should be developed, with a University partner, and with the support of the Trusts and Criminal Justice

Agencies. This programme should provide General Awareness, Basic and Specialist training in keeping with recommendations of "Breaking the Cycle of Rejection: the Capabilities Framework for Personality Disorders" (DH England 2003), and the Knowledge and Understanding Frameworks.
Initially, external specialist courses will be recommended for those who are keen to undertake further formal training. Many suitable courses exist, such as training in specific therapies, and a few are now targeted specifically at working with PD, for example the evidence based Mentalization training provided by Batemen and Fonagy at the Anna Freud Centre in London.

It is anticipated that with time Northern Ireland, initially in partnership with expert external agencies, will become self-sufficient and develop its own regional training team to support training.

Recommendation 12

> A joint regional training strategy should be implemented by the Trusts and Criminal Justice Agencies, following a training needs analysis, using the Knowledge and Understanding Framework and with meaningful user and carer involvement.

8.7 Research

Research is usually either carried out on an established service or an enhanced service retrospectively. However, the development of new personality disorder services here offers the opportunity to undertake prospective study of the developing services which should also ensure services maintain their therapeutic model and quality of service. Also due to both the impact of the Troubles and the level of socioeconomic deprivation, it is postulated Northern Ireland may actually have higher needs in relation to PD than elsewhere in the UK.

The Bamford Action Plan (2009-2011) contained an action on research – *to develop and take forward a prioritised plan for research in mental health and learning disability, by June 2010.* It is essential that the PD Network Group is part of the development of this prioritised research plan in order to promote knowledge transfer from research into practice and to improve outcomes for service users and carers.

Recommendation 13

> While supporting epidemiological needs, including the impact of the Troubles, the priority at this point is for the PD Network Group to feed in priorities into a research action plan for mental health and learning disability, as outlined in the Bamford Action Plan (2009-2011). This will promote knowledge transfer of research findings into practice and improve outcomes.

9.0 IMPLEMENTATION PROPOSALS

The lead for future implementation of the strategy, within available resources, will be with the HSCB and PHA working in partnership with service users and carers, and the statutory and community sectors. The successful development of dedicated PD services, in keeping with the models proposed in this strategy, will be challenging. It is therefore recommended that a Personality Disorder Network Group be established under the auspices of the Bamford HSC Taskforce and tasked with taking forward this strategy.

This Personality Disorder Network Group would include representatives, at a senior level, of the key stakeholder agencies including Criminal Justice, and user and carer representation. Terms of Reference for the group would be agreed between stakeholders and include an Action Plan with specific targets for achievement within set timescales that would incrementally address the recommendations from this Personality Disorder Strategy

There is a need for planned evaluation of PD services against desired outcomes, with clear accountability to the organisations that are responsible for resourcing the achievement of these outcomes. As evaluation in this area is complex it should be standardised where possible across the various agencies, including the Criminal Justice Agencies, and linked to comparative evaluations elsewhere in the UK. It is therefore proposed Personality Disorder Services should be subject to a variety of appropriate service, therapeutic and economic evaluations, to be designed in the planning stages of service development.

Through the Bamford HSC Taskforce, the PD Network Group should produce regular reports on progress and potential for further service developments. It should agree with the Taskfoce the arrangements for the overall review of the Strategy after an appropriate period.

The implementation of both the Personality Disorder Strategy and the Psychological Therapy Strategy, through the Bamford HSC Taskforce will provide an opportunity for linking service developments. Service development should also link with initiatives improving the co-ordination between mental health and children's services in considering the children of parents with PD

Recommendation 14

> An interagency Personality Disorder Network Group should be established by the Health and Social Care Board and Public Health Agency to support implementation of the Personality Disorder Strategy. This should be part of the Bamford HSC Taskforce which will oversee implementation and review of the Bamford Action Plan (2009-2011).

Recommendation 15

> The HSCB and PHA, in conjunction with the Personality Disorder Network Group, should develop the expected outcomes for services to deliver and specific proposals for service evaluation.

Recommendation 16

> An overall review of the Strategy should be carried out, depending on progress with implementation, no later than five years from initiation.

Recommendation 17

> As PD service development progresses, links should be made with other mental health service developments and initiatives through the Bamford HSC Taskforce.

APPENDIX 1

Personality Disorder Working Group

Membership

NAME	REPRESENTING
Dr Ian McMaster (Chair)	DHSSPS
Mr Colin McMinn	DHSSPS
Mr Chris Wilkinson	DHSSPS
Ms Anne Rafferty	NIO/NIPS
Mr Paddy McGowan	Irish Advocacy Network
Mr Desi Bannon	South Eastern HSC Trust
Dr Maria O'Kane	Belfast HSC Trust
Dr Ian Bownes	South Eastern HSC Trust/NIPS
Dr Niall McCullough	NI Division BPS
Dr Raman Kapur	Threshold
Mr Eddie Finn	NIPS
Ms Gail Leeman	Belfast HSC Trust
Dr Geraldine O'Hare	Probation Board
Dr Gerry Waldron	PHA
Ms Jackie Scott	Belfast HSC Trust
Ms Julie Alexander	NI Housing Executive
Ms Julie Lamoureux	Service Users
Mr Paul Bullick	NIPS
Mr Oscar Donnelly	Northern HSC Trust
Mr Seamus Logan	HSC Board
Ms Sharman Quinn	Carers
Mr Trevor Millar	Western HSC Trust
Ms Yvonne McWhirter	Western HSC Trust

Acknowledgement:

The Group particularly wish to thank Dr Olive Lynn, Dr Owen McNeill and Dr Deyra Courtney who undertook a literature search to inform this Strategy.

APPENDIX 2

Therapeutic Community

Therapeutic Community treatment offers a radically different group-based approach for serious neurotic, personality disordered and long-term mentally ill patients, in specialist units. Its principles can be applied to the therapeutic care of a wide range of patient groups in different settings, including the community. The therapeutic community embraces a set of methods which aim to treat people suffering from emotional disturbance in a communal atmosphere. Therapeutic Community principles are based upon a collaborative, democratic and deinstitutionalised approach to staff-patient interaction. Highlighting this approach, patients are generally referred to as residents or members of the community. Traditional staff/staff and staff/member hierarchies are replaced by a more liberal, humane and participative culture.

The Therapeutic Community (TC) offers a safe environment with a clear structure of boundaries and expectations where members have the opportunity to come to terms with their past through re-enactment within a treatment setting involving other members and staff. Group psychotherapy and traditional psychoanalysis are integral to the treatment, but TCs also offer the individual experiences to awaken creative and social abilities. Members tend to learn much through the routine interactions of daily life and the experience of being therapeutic for each other. Through this psychosocial therapy the aim is to encourage members towards a better understanding of their previous behaviour and to enable them to improve their inter-personal functioning, first within the therapeutic community and ultimately in the wider community. Encouraging and reinforcing the notion of personal responsibility and sharing, members and staff meet together on a daily basis to discuss the management and activities of the community, to assess applications for admission and to support leavers.

Members of Therapeutic Communities are not normally detained under the Mental Health Act; attendance is generally voluntary, and to benefit from participation in a TC the member must be positively motivated to change his/her behaviour, to co-operate in group therapy and to accept the rules of communal living.

APPENDIX 3

The Thames Valley Initiative TV1

Tier 1 – Assertive engagement and active assessment.

- Access by self referral to publicly advertised open groups held in easily accessible venues not traditionally associated with mental health provision.
- Organised with numerous agencies at locality level.
- Groups occur in 16 week cycles at the same time and place, take up to 15 people and are facilitated by 3 staff.
- On completion of 16 week programme users can choose to leave, repeat or be referred to another part of the service.

Tier 2 – Outreach, inreach and 'access to therapy'.

- Intensive outpatient treatment, e.g. 2 days per week for at least 16 months.
- Includes weekend programmes for those in full-time work or education.
- Requires larger geographical coverage for formation of appropriate groups.

Tier 3 – Day programme, definitive treatment.

- Locally accessible whole time daily programme 5 days each week and lasting up to 18 months.
- Either mixture of individual group therapies or only groups.
- Therapeutic day unit run as a non residential group orientated therapeutic community.

Tier 4 – Leaving process, graded disengagement.

- Primarily group and up to 18 months.
- Half day per week (or less).
- Liaison with other agencies, e.g. college, employment.

APPENDIX 4

CRACMS

Resettle – Community Risk Assessment and Case Management Service

(A new service for personality disordered offenders in Merseyside to support the work of multi agency public protection panels.)

The Resettle (CRACMS) project is a 4 year researched pilot project, commencing in April 2008, funded by the Department of Health and Health and Offender Partnerships and led by Probation. It will establish an innovative, multi agency community based project in Merseyside for personality disordered offenders on release from prison.

It will be a researched pilot community risk assessment and case management service for released high risk prisoners.

It will:

- Be based in Merseyside.
- Take referrals from Merseyside Multi Agency Public Protection Panels.
- Provide a community based assessment and interventions service for level 2 and level 3 MAPP (Multi Agency Public Protection Panel) cases, with a personality disorder.
- The community based service will also provide in-reach services to prisons and hostels.
- The interventions service will provide long-term support based on a social therapy model, with a high staff: participant ratio.
- Participants will be tenants in the unit.
- The unit will also provide a base for staff, for programmes of work with offenders.
- Provide 24/7 out of hours telephone helpline service.
- A short term crisis and relapse bed will be provided within Probation Approved Premises.
- Interventions will include housing support, employment/education/training, social network, activities and psychiatric/psychological interventions to reduce risk, including substance misuse services.
- The project will work to ensure the longer term support of the individuals at the end of the 3 year pilot, including the development of Circles of Support and Accountability, to maximize the possibility of people remaining in the community and leading productive, offence-free lives.

Research is integral to the project. This area of work is unresearched/poorly researched. The aim of this pilot is to establish whether a co-ordinated community psychosocial provision for Personality Disordered Offenders is effective in reducing re-offending and social exclusion, managing risk in the community and enhancing the quality of lives of individuals.

APPENDIX 5

EQUALITY IMPACT ASSESSMENT

Equality Considerations Northern Ireland Act 1998

Section 75 (S75) of the Northern Ireland Act 1998 places the following statutory requirements on each public authority:

"(1) A public authority shall in carrying out its function relating to Northern Ireland have due regard to the need to promote equality of opportunity –

(a) between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
(b) between men and women generally;

(c) between persons with a disability and persons without; and

(d) between persons with dependents and persons without.

(2) Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group."

Policy Aim and Group Affected

The Personality Disorder Strategy seeks to develop accessible services for people with a personality disorder through a regional framework for multi-agency service development. This assessment will therefore focus on an overall assessment of differential impacts upon relevant groups.

Consideration of the Available Data and Research

Information used includes:

- "Learning the Lessons: A multi-method evaluation of dedicated community based services for people with personality disorder'', Crawford 2007,

- Psychiatric Morbidity among adults living in private households, 2000, the report of a survey carried out by Social Survey Division of the Office for National Statistics,

- NICE Clinical Guidelines for Borderline Personality Disorder

- NICE Clinical Guidelines on Anti-Social Personality Disorder.

Assessment

If all types of personality disorder are considered together there is no significant prevalence difference across the genders. However for specific personality disorders there are differences, e.g. anti-social personality disorder is present in 3% of males and 1% of females, whereas borderline personality disorder is more common in females. Due to this different prevalence of specific personality disorders between genders women are more likely to be in contact with mental health services while men are more likely to be in contact with the criminal justice system or drug and alcohol services.

Personality disorders of all kinds are more prevalent in younger people, especially the 25 to 44 year old age group. There is a reluctance to diagnose personality disorders in children and adolescents before the age of 18.

People with personality disorder are more likely to experience relationship difficulties and therefore not be in a stable relationship, e.g. anti-social personality disorder is commoner in people who are single. Also data collected on ethnicity during the evaluation of community based pilots in England showed the proportion of black and minority ethnic service users referred to be lower than local population estimates, however, could not provide a definitive explanation for this variance.

We do not have robust sources of information on how religion, political opinion, dependent status, disability, or sexual orientation would effect the development of personality disorder.

Overall Conclusion

The Personality Disorder Strategy recognises the significant challenge that people with a personality disorder pose to health, social care and criminal justice services. This Strategy therefore promotes a multi-agency approach to service develop across the range of settings and with meaningful involvement of service users and carers.

Key to success is promoting a positive cultural change throughout services towards people with a personality disorder with recognition of both their needs and the current and emerging positive evidence of benefits from interventions. This will be promoted through the provision of training at both basic and specialist level.

The Department considers that the Personality Disorder Strategy should impact positively on the health and emotional wellbeing of the general population and also does not adversely impact on any of the Section 75 groups and therefore a full Equality Impact Assessment is not required.

APPENDIX 6

BIBLIOGRAPHY

Murmurs of Discontent: Treatment and Treatability of Personality Disorder" Advances in Psychiatric Treatment, Adshead, Gwen (2001) Vol 7 p408

Organisation of Personality Disorder Services in General Adult Psychiatry Services; Discussion paper, Fahy, Tom (2003)

Personality Disorder – No longer a diagnosis of exclusion. NIMHE - DH January 2003

A Crisis Centre for Edinburgh – Lessons form other areas (May 2004) Scottish Development Centre

Training Needs Analysis: Personality Disorder Final Report" Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust in response to a Healthcare Commission Report, Stafford, Clare (October 2007)

Involving Service Users and Carers in Mental Health Services National Schizophrenia Fellowship, Rethink Policy Statement 20

Rethink Research "Do Helplines Help?" Summary Report, National Institute for Mental Health in England

Rethink Severe Mental Illness "Self Help Groups- Self-help groups for individuals who experience mental distress: Proceedings of a self-help group members' symposium and a review of selected literature." The Mental Health Foundation Autumn 2004

National Institute for Mental Health in England "Emerging Best Practices in Mental Health Recovery" UK Version 1 2004

Self-Harm Self Help/Support Groups – User led research on individual's experience of attending a self-harm self-help/support group and the support needs of such groups. The Mental Health Foundation & Community Fund, Smith Angela & Clarke Jill

"Learning the Lessons: A multi-method evaluation of dedicated community-based services for people with personality disorder." Report submitted to the National Co-Ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO) November 2007, Dr Mike Crawford, Imperial College London, The Mental Health Foundation, University College London and Kings College London

Evaluation of Mental Health Investment within the Renewing Communities Action Plan 2006-2008 Pages 27 & 28 Table 3.4 Psychological Therapies Programme Support of Renewing Communities - BHSCT

"Beyond Local Services: Commissioning and Providing Services for People with Complex and Severe Personality Disorders Summary" National Specialised Commissioning Group Meeting of 10 July 2008 - Benefield Nick and Pidd Frankie

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

Psychiatric morbidity among adults living in private households, 2000, the report of a survey carried out by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Executive and the National Assembly for Wales

'Personality Disorder in Scotland – Demanding Patients or Deserving People?' Delivering improved care: A discussion paper, Scottish Executive Mental Health Division

'Mind the Gaps', Scottish Government October 2003

Assessment, risk and outcome in severe personality disorder – The British Journal of Psychiatry, May 2007 Volume 190 Supplement 49

Management of personality disorders in acute in-patient settings. Part 1: Borderline personality disorders, Advances in Psychiatric Treatment, Mar 2004; 10: 93-99 – Leonard Fagin

Management of personality disorders in acute in-patient settings. Part 2: less common personality disorders – Advances in Psychiatric Treatment 2004, Volume 10, 100-106 – Leonard Fagin

Drug treatment for personality disorders – Advances in Psychiatric Treatment, Sep 2004; 10: 389-198. Peter Tyrer and Anthony W Bateman

Psychological treatment for personality disorders – Advances in Psychiatric Treatment, Sep 2004; 10: 378-388. Anthony W Bateman and Peter Tyrer

Services for personality disorder: organisation for inclusion – Advances in psychiatric Treatment (2004) Volume 10, 425-433 – Bateman & Tyrer

Challenges in the treatment of dangerous and severe personality disorder – Advances in Psychiatric Treatment (2007), Volume 13, 325-332 – Howells, Krishnan, Daffern

The University of York, 199 NHS Centre for Reviews & Dissemination, School of Sociology & Social Policy, Nottingham – CRD Report 17

Effective Treatment Models for Personality Disordered Offenders – Craissiti, Horne, Taylor 2002

Psychology, Crime and Law, Special Issue: Personality Disorder and Offending, January 2007 – Hollin, van Koppen, Penrod

A Feasibility Study into Using a Randomised Controlled Trial to Evaluate Treatment Pilots at HMP Whitemoor, Home Office Online Report 14/02

Epidemiology, public health and the problem of personality disorder – The British Journal of Psychiatry (2003), 182 (suppl. 44), s3-s10 – Jeremy Coid

Personality Disorders – www.psychiatryjournal.co.uk Volume 4:3 March 2005 – Tyrer, Garralda, Moran, Hill, Newton-Howes, Bateman, Rutter, Crawford, Maden, Duggan, Seivewright, Rogers, Kirkpatrick

Psychiatric Morbidity among Prisoners in England and Wales. London: Office for National Statistics, Singleton, N, et al (1998)

Briefing Paper: Royal College of Psychiatrists' Centre for Quality Improvement,
August 2008 Core Values and Core Standards for therapeutic communities (TCs) and their application in therapeutic communities and the Community of Communities (C of C) Quality Network

The Personality Disorder Capabilities Framework, Breaking the Cycle of Rejection – November 2003, NIMHE, DH

Report of the Working Group on Services for People with Personality Disorder, Scottish Forensic Mental Health Services Managed Care Network – May 2005

Dangerous and Severe Personality Disorder (DSPD), High secure services for men. Planning and Delivery Guide, DH, MoJ, HM Prison Service – April 2008

Forensic Personality Disorder Medium Secure and Community Pilot Services, Planning and Delivery Guide, DH, MoJ – April 2008

Services for People with Personality Disorder, Mike J Crawford, Psychiatry 7i3, 2008

Personality Disorders, Paul Moran, Marianne Hayward, Psychiatry 6:9, 2007

Delivering for Mental Health, Scottish Executive, 2006

Principles of Managing Patients with Personality Disorder, Sophie Dawson, Advances in Psychiatric Treatment (2002), Vol 8, pp1-9

A Bridge too Far? The Living, Learning Experience of Life and Death in a Residential Therapeutic Community for Personality Disorder in Northern Ireland. Therapeutic Communities, 28, 2, p.147-161 – D Cameron, H Maxwell, R Kapur (2007)

Therapeutic Alliance Evaluation in Personality Disorders psychotherapy. Psychotherapy Research, 15, 1-2, p.45-53 – V Lingiardi, L Filippucci & R Baiocco (2005)

Recognising Complexity: Commissioning guidance for personality disorder services. Department of Health. June 2009

The following documents in respect of the Bamford Review of Mental Health and Learning Disability (Northern Ireland):

A Strategic Framework for Adult Mental Health Services;
The Review of Mental Health and Learning Disability (NI) 2005 Forensic Services;
The Review of Mental Health and Learning Disability (NI) 2006;
Delivering the Bamford Vision; DHSSPS 2008;
Delivering the Bamford Vision - Action Plan 2009-2011; DHSSPS 2009

Psychological Therapy Services Strategy (2009) – DHSSPS Strategy paper

The Bradley Report – April 2009, DH

Improving Health, Supporting Justice. The National Delivery Plan of the Health and Criminal Justice Programme Board – November 2009, DH

APPENDIX 7

ABBREVIATIONS

A&E – Accident and Emergency
ASPD – Anti-social Personality Disorder
BPD – Borderline Personality Disorder
CBT – Cognitive Behaviour Therapy
CJS – Criminal Justice Services
CRACMS – Community Risk Assessment and Case Management Service
DH – Department of Health
DHSSPS – Department of Health, Social Services and Public Safety
DSPD – Dangerous Severe Personality Disorder
GB – Great Britain
GP – General Practitioner
HMP – Her Majesty's Prison
HSC – Health and Social Care
HSCB – Health and Social Care Board
ICP – Integrated Care Pathway
ITC – Itinerant Therapeutic Community
KUF – Knowledge and Understanding Framework
MDT – Multi-disciplinary Team
NHS – National Health Service
NI - Northern Ireland
NICE - National Institute for Clinical Excellence
NIO – Northern Ireland Office
NIPS – Northern Ireland Prison Service
OT – Occupational Therapy
QIS – Quality Improvement Scotland
P2P – Peer to Peer
PD – Personality Disorder
PHA – Public Health Agency
PPANI – Public Protection Arrangements, Northern Ireland
REACH (Reaching prisoners through Engagement, Assessment, Collaborative working, Holistic approach
SPAR - Supporting Prisoners at Risk
STARS – Support, Training and Recovery
TC – Therapeutic Community
TVI – Thames Valley Initiative
UK – United Kingdom