

PS01/20

Services for people diagnosable with personality disorder

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POSITION STATEMENT

Foreword

In 2003 the National Institute for Mental Health England published the landmark document *Personality Disorder: no longer a diagnosis of exclusion*. The document recognised the systemic failings of statutory services to meet the needs of those given a diagnosis of personality disorder. It made a range of recommendations for health and social care services as well as the criminal justice system. The document described a vision for national coverage of specialist personality disorder services targeted at those in most need, whilst ensuring that colleagues in mainstream services were more effectively trained and supported in their practice. This paper was written in a truly collaborative way and heralded a programme of co-produced clinical, training and research projects to address the paper's aims.

The need for the approach outlined in 2003 is even more relevant today, as the evidence to support such recommendations and the knowledge about best practice has grown. Despite this, the gap between knowledge and practice has grown – and the reach of both specialist services and mainstream interventions remains piecemeal and limited.

In January 2018 the Consensus Statement on Personality Disorder was launched by its chairs Norman Lamb MP, Sue Sibbald and Alex Stirzaker. Again, a cross-section of stakeholders raised concerns about the way our society treats people who have difficulties usually associated with the diagnosis of personality disorder. This consensus statement prompted the Royal College of Psychiatrists to consider how it could contribute further to improving care for patients and carers in these services, as well as supporting those who work with these groups.

In drafting this statement the authors have explored the debate around diagnosis. Our conclusions acknowledge the argument that there is the potential for a diagnosis to cause harm, particularly if this is done in a way that lacks appropriate dialogue. However, on balance, we believe that the diagnosis has brought benefits of better describing the impact of such difficulties on people's health and social outcomes, not least the almost two decades of life lost through physical and mental health comorbidities.

Another clear benefit has been to challenge the myth of untreatability whilst supporting the development of services and interventions which are both clinically and cost effective. The diagnostic framework has also supported the development of training and education for patients, carers and staff and for some has been a simple signpost enabling access to the right services and information.

The recommendations in this statement have been drafted with such an understanding in mind. Our ambition has been to address the potential for harm whilst further developing the benefits of a diagnostic framework. Specifically, we are hoping to achieve this through:

- better services in which more accurate diagnoses are made
- an emphasis on engagement that does not rest solely with the patient
- an approach where the presentation is understood through formulation and narrative

- the offering of high-quality and effective treatments
- employment opportunities for people with lived experience to be maximised and to expand these roles across the system
- acceptance that a diagnostic framework remains a key plank in the way that psychiatric practice is organised.

This document has also been written with the NHS England Long Term Plan in mind. We are eager to see the vision set out realised and our recommendations are designed to dovetail with the ambition set out within the plan. So not only is there a sense of urgency but also a sense of opportunity.

Finally, we believe the need for change goes beyond this group of patients; the potential of which was summed up by the contribution of one of the lived experience representatives who stated that if a trust delivers a successful clinical strategy for people with a diagnosis of personality disorder, it is well on the way to being more successful across the board. We agree that effective personality disorder services demand genuine co-production, relational practice and organisations which truly support staff in meeting the challenges of their work.

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Services for people diagnosed with personality disorder

Origin, purpose and limitations of this document

The Medical Psychotherapy Faculty of the Royal College of Psychiatrists convened a cross-faculty working group to explore how to improve the care of people given a diagnosis of personality disorder. The group is formed by representatives from all the relevant college faculties. This statement has been drafted by the group on behalf of the College.

This position statement sets out the Royal College of Psychiatrists' view on:

- the nature of services required to provide high-quality treatment and care for individuals diagnosed or diagnosable with personality disorder
- recommendations on how this can be best implemented and inform health policy.

Whilst this statement is intended to inform policy making across the UK, there are important variations at the level of devolved nations. It is acknowledged that in setting out the background and recommendations, references to the situation in England predominate. For Scottish policy makers this guidance should be read in conjunction with *Personality Disorder in Scotland Report: Raising awareness, raising expectations, raising hope* (RCPsych, 2018) published August 2018. Northern Ireland has both a strategy and pathway that have been developed and implemented over several years: *A Diagnosis of Inclusion* (Department of Health Northern Ireland, 2010) and *Regional PD Care Pathway* (Regional Care Pathway for Personality Care Disorders in Northern Ireland, 2014) respectively.

There are several areas which are beyond the scope of this general document, and suggestions for further work by the College are made in Appendix 4. This statement and its recommendations are primarily about adult services, although basic references to children and young peoples' services are made. However, there are important differences and a multi-stakeholder paper about children and young people is planned.

Work with people with a diagnosis of personality disorder typically involves working across different agencies and sectors, including social care, housing, education, justice and physical healthcare. Although the focus of this statement is on the health sector, it includes consideration of how psychiatrists can support work in these other sectors through evidence-based interventions, as well as by education, consultation and clinical leadership.

Background

In the early 2000s (Warden, 1998), the Department of Health established the National Personality Disorder Development Programme to develop and investigate suitable community provision in a number of different pilot sites in England. In 2003 it published the policy implementation guide *Personality Disorder: No longer a diagnosis of exclusion* (Department of Health, 2003). The programme's initial findings established the paucity and variability of provision and it presented principles of good practice; a linked process led to a workforce development guide *Breaking the cycle of rejection: The Personality Disorders Capabilities Framework* (NIMHE, 2003). This set the scene for the creation of a national training programme (the Knowledge and Understanding Framework or KUF).

The pilot projects demonstrated how different approaches with common underlying principles could deliver cost-effective solutions (Wilson & Haigh, 2011) and the training programme was widely implemented. Regrettably, the community aspect of the programme was closed in 2011 and nationally coordinated personality disorder development work only continued in the criminal justice sector. More details are given in Appendix 3.

Since then, ad-hoc service development has taken place in England. There remains considerable variation in whether services are available, what they offer and to whom, with little clinical strategy at regional or national level. Availability of treatment remains more dependent on geography rather than need. This picture is described in the 2015 National Personality Disorder Service Survey (Dale et al, 2017) which looked at service provision in England. The same survey methodology has since been applied in Scotland and Wales with similar findings.

The *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (University of Manchester, 2018) describes the care received by patients before they died by suicide or committed homicide. For those who had died by suicide, a consistent finding was that, despite the majority having had long-term contact with mental health services, only 4% had contact with specialist services. For both groups, patients were not receiving the psychological care recommended by NICE. Among people who die by suicide, more than half are likely to have suffered from a diagnosed personality disorder (Cheng et al, 2000) and in prisons approximately 60–70% are estimated to satisfy the diagnostic criteria for personality disorder (Singleton et al, 1998).

Tiers, severity, stepped care and pathways

Personality disorder services for adults are arranged in tiers. These define increasing the intensity of intervention (for greater severity) and reducing the number of patients (assuming greater severity is rarer) in the consecutively higher tiers. No satisfactory measure or definition of severity has gained widespread professional acceptance, although ICD 11 (WHO, 2018) heralds the first formal attempt to make it a defining feature of personality disorder diagnosis, with levels of 'difficulty', 'mild', 'moderate' and 'severe'.

There is general agreement that for most people with personality disorder local outpatient treatment programmes are effective. Clinicians working with mild and moderate difficulties require less-specialist skills and team structures to engage these patients in regular

sessions. Such Tier 2 (mainstream) services are commonly established in localities or provider NHS trusts. A clinical service that only provides stand-alone and time-limited therapy programmes cannot, however, provide a suitable therapeutic system and setting for those with more chaotic lives and a greater severity of disorder. Engaging this group demands highly-specialised working practices and clinical skills. A strategy which emphasises non-specialist services working for all runs the risk of being unable to effectively engage those with the most pervasive personality disorders; arguably those most in need. This also means that those with additional, comorbid conditions can be denied access to effective treatment. Preventing this exclusion is the work of all tiers; however, those with more severe difficulties require more specialist support in order to achieve this, hence the need for Tier 3 (local specialist) and Tier 4 (regional or national specialist) services. This model ensures best use of resources across all the tiers (NHS Improvement, 2018).

The table illustrates the main differences between the four tiers of non-forensic provision in adult settings.

Table 1				
	Tier 1	Tier 2	Tier 3	Tier 4
Setting	Primary care, voluntary sector.	<ul style="list-style-type: none"> • Mainstream CMHT • Liaison services • Acute and crisis services • Psychological services • Psychotherapy services. 	Local, semi-regional specialist and dedicated PD services, incorporating outpatient, day-patient and 'partial hospitalisation' interventions. These often require attendance that is more frequent than once a week.	Regional or national specialist services.
Beds	None.	No specialist beds but work alongside crisis and acute services.	No specialist beds but work intensively with crisis and acute services to prevent admission.	Yes: mostly residential services for out-of-area referrals; some integrate consultation and step down.
Patient group	Those gaining sufficient help from low-intensity and short-term psychosocial treatments.	Able to engage and participate in outpatient short-to medium-term psychosocial intervention. Occasional use of crisis/acute care.	Not successfully engaged or treated by Tier 2. High level of risk and/or disability. Frequent use of unplanned contacts and crisis/acute care. Includes older adults.	Risk level too high to be managed in Tier 3. Therapy requires a setting with highest level of psychological containment. Very high use of crisis/acute care.

	Tier 1	Tier 2	Tier 3	Tier 4
Type of therapy	<ul style="list-style-type: none"> IAPT Psychological education Consultation services Wellbeing networks Recovery colleges Social prescribing Self-help groups Moderated online forums. 	<ul style="list-style-type: none"> Psychological education 'Structured Clinical Management' 'Good Psychiatric Management' Evidence-based outpatient psychological therapies (e.g. MBT, DBT, DIT, STEPPS, TFP, psychodynamic therapy etc). 	Greater intensity of intervention. Emphasis on therapeutic setting and supporting effective engagement.	Intensive, complex multi-modal treatment programmes, integrating therapy and setting.
Approximate estimate of likely need	Up to 4% (= 2.2M for England or 4K per 100K adult population)	0.4% (= 224K for England or 400 per 100K adult population.)	0.04% (=22k for England or 40 per 100K adult population.)	0.004% (=2240 for England or 4 per 100K adult population: 2,120 in England.)
Current provision	Unknown. IAPT may exclude those with a diagnosis of personality disorder if they are not clustered 1–3 with HoNOS. Some recovery colleges allow step down access.	Extremely variable. Although 53% of English MHTs claim to have dedicated T2 services or teams (Warden, 1998), many of these are likely to offer minimal and small-scale provision.	Although 56% of English MHTs claim to have dedicated T3 services or teams (Warden, 1998), few of these are likely to accommodate the core T3 'difficult to engage' population. Northern Ireland has more developed T3 services.	55 beds in England, in 4 units. Many more people are placed in independent sector specialist units and locked non-specialist units (e.g. 'locked rehab').
Commissioning	Various.	CCGs.	CCGs.	NHSE (CCGs for most independent sector 'out of area' placements).
Specification and standards	Needed.	Needed.	Needed.	Being developed by NHS England.
Providers	Social care, primary care, third sector.	NHS trusts.	NHS trusts and partnership arrangements.	NHS trusts and independent sector.
Access	Open, self-referral.	Via GP, CMHT, local procedures.	Via GP, CMHT, local procedures.	Restricted, only via T3 (where available) or T2.

Tiers 5 and 6

Details of forensic services are beyond the scope of this document, but tiers 5 and 6 describe secure provision with which pathways need to be built. Many forensic mental health services offer medium-secure hospital provision with some specialist treatment for offender-patients diagnosed with personality disorder, sometimes referred to as Tier 5, as well as high-secure hospital services (Tier 6). The Offender Personality Disorder Pathway (OPDP) strategy has, since 2011, been developed as a structured approach across mental health provision, prison and probation services. In the National Probation Service (NPS) this is based on screening of the caseload, consultation and provision of formulations between NHS and HMPPS personality disorder specialists and Offender Managers (probation officers), with limited joint working. It followed the demise of the so-called 'dangerous and severe personality disorder programme' (DSPD) (Duggan, 2011). Potential elements in the pathway include the fourteen therapeutic communities in the prison estate, new treatment services in Category A (high security), Category B and Category C prisons, Psychologically Informed Planned Environments (PIPES) and community intervention services linked to the National Probation Service. The pathway continues to include three specialist medium-secure hospital units.

CAMHS systems

Services for children and young people are moving away from a tiered approach to a whole systems framework, which focuses on getting the right support at each stage, from early intervention to managing more severe, risky presentations.

Thrive is an example of such a model which is referenced in the NHS long term plan and being rolled out across NHSE (Wolpert et al, 2015). The THRIVE framework conceptualises five needs-based groupings for young people with mental health difficulties and their families: thriving; getting advice; getting help; getting more help and getting risk support. Each of the five groupings is distinct in terms of the: needs and/or choices of the individuals within each group, skill mix required to meet these needs, dominant metaphor used to describe needs (wellbeing, ill health, support), resources required to meet the needs and/or choices of people in that group. The groups are not distinguished by severity of need or type of problem. Rather, groupings are primarily organised around different supportive activities provided by children and young people mental health services in response to mental health needs and influenced by client choice.

Practice considerations

Overall approach

The presentation of personality disorders is characterised by difficulties in interpersonal relationships and this should be reflected in service approaches (Lothian & Read, 2002; Foulkes, 1983). Sound assessment of personality disorder and its treatment form an area of practice where all aspects of biopsychosocial formulation should be considered. Psychiatrists and medical psychotherapists are particularly well placed to do this. Attention must be paid to the impact of staff on patients and vice versa.

Effective leadership is critical to ensuring quality of care at any level of severity, as is regular opportunity for reflection with a skilled colleague. For people with more severe disorders, treatment and management should be carried out by a team with close and frequent contact, able to implement a consistent and coherent approach, with good reflective practice and opportunities for psychotherapeutic supervision. Treatment for people with severe disorders requires a planned therapeutic environment which can be maintained over long periods. This is particularly relevant for the transition period between CAMHS and adult services (NICE, 2016).

Diagnosis

The use of the personality disorder diagnosis has facilitated progress in several areas: expanding epidemiological knowledge; enabling the design and evaluation of specific treatments; establishing training; and increasing public awareness. The health and social problems associated with the diagnosis are well recognised (Fok et al, 2012; Moran et al, 2016). However, use of the diagnosis remains variable; clinicians may avoid it by using other diagnostic categorisations. Some use it only for the most severe cases and others do not use it at all. This variability of practice undermines efforts to recognise the scale of morbidity, commissioning needs, design of services, evaluation of treatment and research.

Ambivalence among professionals is paralleled by concerns, among some patient groups and others, that the diagnostic label itself can lead to stigma. Some have called for the diagnosis to be renamed, others that the procedure of making a diagnosis may itself produce harms in this population. There is a general agreement that diagnosis alone is insufficient and good care should be guided by a co-constructed biopsychosocial formulation which gives patients an experience of being understood. A diagnosis should only be made after appropriately skilled and thorough assessment, although this should not cause a delay in receiving suitable interventions and care.

Manifestation of personality traits which interfere with a person's life may arise at any stage of development. It is common for difficulties constituting a disorder to appear in childhood or early adolescence. However, diagnoses of personality disorders are not routinely made in child and adolescent mental health services. There may be some rationale for these decisions. For example, whilst up to 50% of children with conduct disorder may go on to develop antisocial personality disorder (NICE, 2013), 50% of children will not.

However, a reluctance to use a personality disorder diagnosis in children and young people can mean that inaccurate diagnoses, such as depressive disorder, are given in adolescence and, consequently, inappropriate or ineffective treatment may be offered with the potential to cause harm. Other diagnoses such as disorders of conduct and emotions do not link to helpful treatment pathways. ICD-11 (Dale et al, 2017) facilitates the diagnosis of personality disorder in patients over 14 years of age. In order to ensure accurate and consistent epidemiological data is collected and that appropriate evidence-based treatments can be evaluated and offered to young people with these difficulties, it is important that the diagnosis is made in this age group.

However, it is important that all clinicians consider personality difficulties as part of a wider biopsychosocial formulation. This may include a number of differential diagnoses such as ADHD (which may be present with emotional dysregulation and impulsivity) and Autistic spectrum conditions (which can have an impact on emotional regulation) and Post-traumatic stress disorder which can similarly affect individuals. It is also important for clinicians working with children to be aware that diagnosis only forms a limited part of understanding and working with young people and their carers. Not only will attachment issues continue to have a prominent influence but particular attention should be paid to psychosocial and systemic factors in understanding presentations.

Personality disorder is an enduring condition which interferes with the sufferer's sense of wellbeing and ability to function in full in ordinary social settings. It is probably best regarded as a developmental disorder, which can create a specific difficulty in which neither the adult patient nor the clinician is sure of the potential of the patient. Generally, in relation to mental illness, there is the concept that the treatment aim is to restore the individual to a previous healthy state. With personality disorder, however, there is often no such easily demarcated baseline. Regardless of aetiology, it could also be said that personality disorder reflects a degree of neurodiversity similar to other neurodevelopmental disorders. This is why a co-created biopsychosocial formulation is critical to establishing personal health and social care aims for each patient.

Psychosocial aetiology

A good understanding of personality disorder phenomena is not possible without using sophisticated psychological models that draw on in-depth approaches such as psychodynamic theory and attachment theory. More recent frameworks, such as 'mentalising', 'trauma-informed care' and 'relational practice' are also relevant, as are cognitive models.

Adverse Childhood Experiences (ACEs) are strongly associated with personality disorder and are increasingly recognised as a serious public health concern (Public Health Wales, 2016; National Scientific Council on the Developing Child, 2012). However, although they are clearly important, there is no simple causal relationship: many patients who are diagnosable with personality disorder have no apparent history of emotional trauma or deprivation and many people with traumatic, abusive and deprived histories are not affected in a way that leads to contact with mental health services. Caspi et al (2002) have offered evidence for genetic polymorphism moderating environmental effects, which may account for this discrepancy in antisocial behaviour (Caspi et al, 2002).

This aetiological uncertainty is compounded by the nature of ACEs as well as the state of statutory services: holding difficult conversations which identify problems of emotional development requires skilled, well-supported staff, as well as service capacity and flexibility to ensure people are given the time and space to explore such narratives. Despite advice to support better psychiatric formulation, many of these testimonies remain hidden. Lothian et al (2002), for example, in a survey of mental health service users, found that less than 22% reported being asked about child abuse. To improve this, more adequately skilled staff are needed in statutory services, who are supported and trained to understand the basic dynamics of transference and countertransference. Otherwise, we risk repeating these toxic and persistent relationship styles into adulthood.

Within CAMHS, safeguarding and social care teams play a key role in supporting children and families affected by ACEs. Ensuring that there are robust frameworks for good communication between such services, and that treatment is available as close to the traumatic experiences as is possible is key when working with children and young people, particularly those who may be 'looked after' children or 'children in need'. Current thinking suggests that when devising a specific early intervention programme, it is vital to recognise that the need for treatment may not be dependent on diagnosis. In other words, better outcomes may result if we stop waiting for people to 'get bad enough' to receive a diagnosis, before help is offered.

In addition, supporting parents with personality disorder in the peri-natal period and early years is crucial to help address inter-generational patterns. Parenting interventions, monitoring of safeguarding concerns with other relevant agencies, and early assessment and intervention of mental health difficulties in young children are all important to ensure optimal outcomes for children.

Neurobiology

The biological influences upon personality disorder development remain controversial; however, a range of evidence exists to support a neurobiological role. Gunderson et al found substantial familial aggregation for borderline personality disorder. This equated to a risk ratio of 2.9 in individuals with a family member with borderline personality disorder against those without (95% confidence interval 1.5–5.5). The relationship between genetics and environment is highly complex and pitting genetic drivers against environmental is unhelpful (Gunderson et al, 2011). Acknowledging a dynamic and complex interaction is critical to understanding the manifestation of these conditions (Butz, 2018).

Genetic studies, including twin studies, have focused on dopaminergic and serotonergic pathways of neurotransmission (Reichborn-Kjennerud, 2010). Some have posited an endophenotypic relationship and early aberrant methylation has been demonstrated in borderline personality disorder (Teschler et al, 2016). The role of epigenetics and methylation on the oxytocin receptor gene has been considered to have a mediating role with variability in this gene's expression linked to the ability of emotional face recognition of fear and anger (Herpertz et al, 2015).

The biological impact of these interactions has largely focused on amygdala and hippocampal activity. Examining the volume of these specific areas and their function, using fMRI scans, has identified differences (Ruocco et al, 2016). These differences have even been shown to attenuate following treatment with Dialectical Behavioural Therapy and that such an effect is correlated with subjective measures of emotional regulation (Goodman et al, 2014). The interpretation of such evidence remains open, as studies have given conflicting results. Some believe this may reflect differences in subgroups, the artificial nature of the laboratory setting or the use of subjects who are taking medication (New et al, 2007).

Medication

Medication can offer symptomatic relief to people with personality disorder but there is no evidence yet of a medication which is effective in changing the disorder itself. No drug has a specific license for the treatment of personality disorder. It is therefore a cause for concern that 92% of patients with personality disorder in the UK are prescribed psychotropic medications (Paton et al, 2015). Although comorbidities are commonly cited as the reason for prescribing, NICE discourages the use of medication in borderline personality disorder. The 2010 Cochrane Review of pharmacological interventions for borderline personality disorder found evidence of some beneficial effects of certain medications for specific symptoms and signs but were mostly based on small, short-term, un-replicated studies (Duggan et al, 2008).

Aside from any direct treatment effects, use of medication is fraught with symbolism. Symptom relief by medication is seen by some as an impediment to therapeutic progress. Some medications have a sedative effect, some are emotionally blunting. In terms of illness behaviour, the giving and receiving of medication can promote the idea of 'being sick', which can reduce an individual's sense of personal agency and encourage belief in an external locus of control. Clinicians and pharmacists are often concerned about the trend towards polypharmacy and overuse of medication (Crawford et al, 2011; Martin-Blanco et al, 2017), with the attendant risks of long-term psychiatric drug treatment (Moncrieff, 2008). Prescribing can easily arise inappropriately when psychiatrists lack the experience and confidence to manage the pressure to resolve distress and when psychotherapeutic services are not available to offer a viable alternative.

Being able to work with the uncertainties around diagnosis, the evidence base and the symbolic meaning of a prescription makes prescribing in such an area complex and demands a highly-skilled clinician. Conversely, a simplistic approach, in which patients are denied access to psychotherapy or therapeutic communities until they give up medication, is not recommended. With some patients, medication may provide a sense of mental stability that is needed for them to be able to engage in psychological therapy. A validating experience, which is honest about the implications and expectations of medication, can be given to the patient who is then supported in making the best decision for themselves, followed by a collaborative decision based on fully informed choice and then consent is the optimal pathway.

Relational continuity

Evidence from primary care underlines the importance of the doctor–patient (or other professional) relationship in preventing hospital admissions for people with personality disorder (Hansen et al, 2013). For all patients, but especially those with personality disorder, the therapeutic relationship is of central importance. It is both through continuity and incorporating the biographical context that services can avoid giving aversive and blaming experiences for patients. Continuity across the transition between CAMHS and adult services is particularly important (NICE, 2016).

Recent service designs have resulted in the loss of relational continuity through offering discrete and disconnected interventions, with a tendency to focus on risk management through acute services. Where this remains the clinical emphasis, insufficient attention to the

overall therapeutic environment is made and the experience of psychological containment across different parts of a system is undermined. This lack of relational continuity often leads to escalating risk behaviours so that patients access, or maintain a place in, a service to continue a relationship with the staff or peers within it. Over-dependence can also cause problems seen in the transference or counter-transference, and should be properly managed through reflective practice and suitable supervision. The nature of personality disorder is that it is a long-enduring condition with episodic exacerbations and the clinical strategy needs to reflect this. An effective care system requires a mixture of services but very often needs a core adult community setting which is able to 'hold' the patient's story, and incorporate continuity between services, including between hospital and community settings.

Being sensitive to the changing needs whilst holding a sense of belonging for the patient requires a mixture of acute, planned and specialist working in a coordinated pathway. This means clinicians can make the most of brief, intervention-orientated contacts, whilst ensuring the patient is left with a sense of purpose in their treatment and that, if more long-term treatments are required, they are utilised as safely and effectively as possible. Through such a system, a well-resourced community mental health team can manage most patients whilst supporting the time-limited interventions of the more specialist services for those in greatest need. Such a relationship between specialist and mainstream services allows for effective division of tasks; flow of expertise; maintenance of local connections during specialist treatment; and, fundamentally, a relational continuity that crosses service boundaries.

Staff needs

Staff across all sectors report they feel insufficiently supported when working in this clinical area (NIMHE, 2003), including many who are suitably trained and have long experience. Feelings of inadequacy and hopelessness can be inherent part of working with personality disorder. When these experiences are not well contained, they can lead to therapeutic nihilism and a negative service culture. For example, unsupported staff will fear and avoid the necessary emotional contact, work defensively and too often declare patients un-engageable or untreatable. In non-specialist settings, the consequences of this can be interventions which represent retreat into simplistic impersonal solutions (such as a reactive prescription of medication), punitive reactions (such as seclusion or arrest), referral to services with higher levels of physical containment or expulsion from services altogether. These dysfunctional processes in staff, which are not always conscious, are well described (Menzies, 1960; Markham, 2003; Aviram et al, 2006; Bodner et al, 2011). The nationally commissioned Knowledge and Understanding Framework was successful in meeting some of these needs in the past (Davies et al, 2014) but its availability is now limited and will be until the new programme has been commissioned later this year (2020). Such training will need corresponding service development to realise the educational benefits.

The essential workforce requirements for all disciplines are:

- 1 Selection of suitable staff able and willing to work at the required emotional level.
- 2 Good training, to understand the nature of the disorder and develop the necessary approaches and skills for it.
- 3 Supervision and reflective practice with adequate time to reflect on the personal impact of the work.
- 4 Formal and informal support (usually through healthy team functioning).
- 5 Personal therapy may also be required, depending on the individual circumstances.
- 6 Experts by experience (and carers) should be involved in training.
- 7 Exposure to and experience of working in or with the different elements and tiers of the whole pathway.

Any training and staff development strategy must meet these seven requirements, as well as giving attention to how different services can collaborate, for example placements in specialist services for mainstream staff, and vice versa, or dividing individuals' jobs between the different settings. The commissioning and administration of training needs to be organised so that the above seven principles are realised. The College must work actively to support the training required for theoretically sound, relationship-based and suitably evidence-based practice.

Organisational needs

Within all health organisations, senior managerial leadership should ensure that anxiety about the most concerning patients is managed therapeutically. In NHS Foundation Trusts, for example, this requires a board-level understanding that treatment of personality disorder cannot be delivered through simple discrete health interventions or packages. A more sophisticated, systemic and formulation-informed understanding is required.

These patients often present a high risk of seriously damaging acts, most often to themselves but sometimes also to others. Thus, the inevitability of serious, untoward incidents must be recognised within a framework, based on a trusting and secure relationship between senior management and clinical staff. A culture of psychological containment, where staff have the confidence to take short-term positive risks to achieve longer-term positive therapeutic outcomes, should be established and maintained. This happens through assurance that staff and patients have paid attention to risk dilemmas, explored the options thoroughly and shared the burden of responsibility, as far as possible, in a clearly documented way. A lack of such thoughtfulness can drive critical and punitive reactions, leading to unnecessarily defensive and harmful practice.

Effective organisational containment also requires a well-functioning pathway. Clear routes for escalation and thresholds for access to higher tier services are essential. This allows lower levels of intervention (with higher volumes of patients) to be conducted

in an atmosphere of greater effectiveness and safety, in the knowledge that those of greater complexity and risk are receiving expert and thorough consideration.

Pathways between child and adult services are crucial; although the exact age of transition varies between services, this is a very sensitive time in maturation and development (NICE, 2016). Additionally, in many areas, crisis teams who are hosted within adult services provide out-of-hours support to children and young people. Consideration must be given to ensuring that there are clear systems for sharing information about formulations, diagnoses and risks - to ensure that all teams have a shared understanding of young people and how to respond appropriately to personality disorder presentations before adulthood.

Effective leadership requires establishment of a supportive team ethos, understanding of the containing system and the need for predominantly relational approaches alongside clarity of roles and boundaries. The College Centre for Quality Improvement's Enabling Environments network provides a developmental process for services and teams with a quality benchmark that promotes and recognises these qualities.

Overarching recommendations

- 1** The College will ensure that all psychiatrists are trained in the assessment and diagnosis of personality disorder, theories of aetiology, and treatment approaches including optimisation of the therapeutic setting, relational practice, communication of the diagnosis, the appropriate use of medication and specific psychotherapies. This will happen throughout their core and specialist training, and continuing professional development. This may require some re-education in consideration of young people and neurodevelopmental disorders; this should be given equal weight to the training in conditions such as ADHD and autistic spectrum, and to aid identification of the different therapeutic needs
- 2** The College will play a leading role in developing suitable training for other professional groups through its relationships with relevant national bodies. As well as health, this includes criminal justice, police, social services, education, housing, homelessness and others.
- 3** Each NHS Trust, or equivalent, should appoint a Personality Disorder Lead, with responsibility for ensuring that a coherent clinical pathway across all tiers is available, including within CAMHS and the transition to adult services.
- 4** Patients with personality disorder should not be denied mainstream services based on diagnosis alone. Mainstream services should make suitable adjustments to support access for patients with personality disorder, ensuring equal access to both men and women and ‘hard to reach’ groups, such as young men who may be in prison or on licence with probation services.
- 5** Where clinically indicated, all patients should have access to locally accessible Tier 3 provision, within an appropriate setting, with suitable staffing and meeting nationally recognised quality standards (for example, the RCPsych Enabling Environments award). The Tier 3 services work as an adjunct to the local Tier 1 and Tier 2 services and with mainstream locality and acute teams.
- 6** Each adult Tier 3 service needs to have access to a specialist residential Tier 4 personality disorder service which should have the capacity to work with those who are detained under mental health legislation as well as voluntary patients. These Tier 4 services should work collaboratively with the lower tiers of services from which its patients are referred and should include secure hospital provision for those who pose serious risks to others while untreated or partially treated. Similar specialist arrangements need to be developed in CAMHS.
- 7** Many patients with personality disorder, sometimes with various comorbidities, are placed in locked residential rehabilitation facilities. These units often lack suitable programmes and expertise for effective engagement and treatment. This system, and the individuals in it, needs to be reviewed to ensure these patients are treated in clinically suitable services which are least restrictive and are integrated within local and regional services (Tier 3 and Tier 4).

- 8 Services for children and young people should offer a full range of specialist outpatient and inpatient interventions for those with emerging and diagnosable personality disorders. Their treatment should be coordinated with local specialist services for adults with personality disorder and sound transition arrangements between services should be assured when necessary.

Detailed recommendations

1. Diagnosis and formulation

Although there is concern about the personality disorder diagnosis – both among patients and among clinicians – at this stage there is a risk that changing terminology will simply cause confusion and divert attention (and funding support) from the need to develop accessible, effective and safe services. Practice and training recommendations that can manage, mitigate and potentially avoid any harmful aspects of the diagnostic label should be developed. Formulation, as far as possible jointly created with the patient, should be emphasised as the basis for understanding the patient and their needs and goals. Teams should be proficient at working with those who have been subject to abuse, neglect and other forms of psychological trauma. This will include considerable expertise in safeguarding.

Recommendations:

- 1.1 Diagnosis should only be made by those qualified to make it and only following a thorough assessment. This should be arranged so that it does not cause delay in patients receiving appropriate treatment. The results of numerical questionnaires are not sufficient as a primary method of diagnosis.
- 1.2 Clinicians should be open about the limitations of diagnosis and psychological education should be made available to patients and carers.
- 1.3 Training for core professionals should emphasise the relevance of early experiences, prompting staff to consider asking the patient “what has happened to you?” in preference to “what is wrong with you?”.
- 1.4 Where possible, correspondence should avoid technical jargon and be addressed to the patient and copied to professionals, such as the GP, and carers where appropriate.

2. Engagement, relational practice, co-production and shared ownership

Successful services recognise that difficulties with engagement are an intrinsic part of the work and are a problem that staff, patients and carers should share. Interventions that do not recognise the relevance of the therapeutic relationship are generally unhelpful and can be harmful. Patients often enter services feeling highly marginalised and isolated. Addressing this successfully can be achieved by involvement in general decision making and democratic processes, as well as social and occupational activity.

Recommendations:

- 2.1 All adult patients in Tiers 2 and above should be allocated a lead clinician who can support the patient through the engagement process and in making informed choices about options.
- 2.2 This role is long term and supports patients into and out of interventions.
- 2.3 These clinicians must have clear lines of supervision and support.
- 2.4 Services should ensure a range of psychosocial options are available.
- 2.5 Democratic processes need to be present to allow patients to affect change within their own services.
- 2.6 Specialist services should employ people with lived experience, through suitable HR processes and with suitable remuneration and employment benefits. This should be done in a way to encourage further professional development.
- 2.7 In effective services, a proportion of ex-patients are likely to train as clinicians of various disciplines. This should be encouraged.

3. Training and workforce development

Without good selection, training, supervision and support, clinicians are likely to become less motivated, may burn out and services are likely to become ineffective and possibly fail.

Recommendations:

- 3.1 Staff selection for specialist personality disorder services should include the views of current service users, ex-service users and others with appropriate lived experience.
- 3.2 The working culture of specialist personality disorder services should encourage and support staff to seek personal therapy if they feel that it is necessary or would be helpful.
- 3.3 All staff, including non-clinicians, need to have a continuous programme of training for the work.

- 3.4 Personality Disorder training programmes should incorporate experiential learning.
- 3.5 All staff have clinical supervision, either individually or as staff groups. This should be as a ratio of 1:10 for qualified staff and 1:6 for trainees (hours of supervision: hours of face-to-face contact).
- 3.6 Teams should undertake a range of reflective practice activities which can contribute to this level of supervision.
- 3.7 Organisations must establish systems that ensure lessons are learned from routine practice and 'near misses', and not only from serious untoward incidents. Mainstream mental and physical healthcare services across the NHS should ensure all staff have access to appropriate personality disorder training
- 3.8 RCPsych should consider its curriculum recommendations to the General Medical Council in light of this statement and give training and education in personality disorder a higher priority.
- 3.9 Health Education England should be involved in the current review of the KUF programme and support substantially increased capacity to meet these requirements across all relevant disciplines.
- 3.10 Health Education England and NHS Trusts should develop local training strategies to meet these requirements.
- 3.11 Although this document only applies to services in the health sector, consideration must be given to training and development opportunities in other relevant sectors (namely social care, criminal justice, housing, education and the voluntary sector) and the mutually enhanced benefit of cross-agency and cross-sector training.

4. A whole pathway approach

Pathways are most effective when they provide the most suitable care as close to home as possible but equally recognise the role of regional and national specialist provision for those with the most significant needs. A stepped care model ensures that higher intensity treatment is only offered when necessary. Regardless of where the treatment is delivered, local connections, through the care programme approach (CPA), must be maintained.

Pathways must operate within a system of close administrative and clinical cooperation. This includes the availability of upwards referral when somebody is not engaged or deteriorating or causing dynamic problems within a group or service, indicating a need for greater intensity of intervention. Failure to engage or respond to treatment efforts should prompt the service to respond creatively and with a greater emphasis on developing a milieu which supports engagement.

Pathways should ensure that specific requirements for transition of patients moving between services, such as CAMHS and adult services are met and that there is the opportunity for early intervention, including in the perinatal and early years periods so as to reduce the need for services later in life.

The NHS England Long term plan is encouraging CAMHS to explore alternatives to a purely health-led tiered system. This includes integrated working with other systems such as social care and education. Assessment & diagnosis in young people should be undertaken with appropriate expertise and time (Wolpert et al., 2017). Consideration must be given to alternative differential diagnoses and comorbidities which can cause emotional dysregulation or instability. Caution in the diagnosis of personality disorder in children and young people is understandable as, by definition, their personalities are still developing. However, clear personality disorder syndromes are often seen years before the young person becomes an adult. In such cases it is important to avoid the use of spurious alternative diagnoses as this can cause harm and undermine the development of appropriate interventions. A provisional diagnosis of 'emerging personality disorder' allows for accuracy of diagnosis whilst remaining open to the possibility that it will not be sustained in the long term.

Recommendations:

Mental health commissioners and providers should ensure a functioning pathway operating across all tiers. For the devolved nations the guidance remains relevant but local commissioning structures will need to be consulted. Clear pathways to enable information and referrals to flow from child to adult services must be developed. It is important for CAMHS clinicians to be linked to their trust personality disorder lead in order to ensure that evidence-based services are offered to young people and that good transitional links are in place to adult services (NICE, 2016).

4.1 Tier 1:

- 4.1.1 Primary care psychological interventions should not exclude service users with a diagnosis of personality disorder.
- 4.1.2 General practitioners should have access to support and supervision in working with people with personality disorder: both managing them within the practice and knowing when and how to refer onwards.
- 4.1.3 Recovery Colleges, providing psychological education, should offer a range of relevant personality disorder interventions.
- 4.1.4 Other voluntary and third sector organisations need to be encouraged to coordinate and cooperate with the statutory sector pathways, including using social prescribing.
- 4.1.5 Peer support and self-help groups need to be linked to the pathways and be suitably supported by statutory services

4.2 Tier 2:

- 4.2.1 A range of specific, evidence-based interventions for people with personality disorder should be available in all localities on an outpatient basis.
- 4.2.2 Services should be multi-disciplinary and 'multi-model', that is they should offer a range of biological, psychological and social interventions, in a relational context.
- 4.2.3 Structured management approaches such as *Structured Clinical Management* (Bateman & Krawitz, 2013), should be available in community mental health teams and overseen by local specialist services.
- 4.2.4 Where patients are not able to engage, consultation can be sought from Tier 2 teams. This can help them to support and manage complex patients without the risk of falling into patterns of engagement which are unhelpful and exacerbate risk.
- 4.2.5 Interventions should be embedded within core psychiatric services.
- 4.2.6 Services should adopt systems to identify patients with whom they are struggling to engage and promote engagement.
- 4.2.7 Services should facilitate engagement with preventative, primary and acute care to promote physical health and wellbeing.

4.3 Tier 3:

- 4.3.1 Each trust must ensure that there is a dedicated and specialist personality disorder service delivering a therapeutic milieu-based treatment approach.
- 4.3.2 The patient group should be defined through Tier 2 and core psychiatric services being unable to offer interventions which can establish and maintain engagement. Tier 3 services might include 'partial day-hospitalisation', various individual and group psychotherapies and family interventions. They also need facilities and procedures to assertively engage those who are unable or unwilling to attend hospital or community clinics.
- 4.3.3 A Tier 3 programme should offer a range of interventions which support the establishment of an effective therapeutic setting. This could be achieved, for example, through participation in the RCPsych's Enabling Environments quality improvement programme.
- 4.3.4 Specialist Tier 3 services should offer flexible but time-limited programmes which may be arranged in phases to facilitate the process from engagement and assessment to rehabilitation, discharge and recovery.
- 4.3.5 Tier 3 services should work with a shared care model with Tier 2 services so that continuity and step down is achieved.

4.4 Tiers 2 and 3:

- 4.4.1 Every trust should have an identified personality disorder lead for adult services and CAMHS who has an overview of the pathway and the requirements to develop services locally.
- 4.4.2 Every trust should have a risk panel or complex case meeting to support clinicians in making high-risk decisions.
- 4.4.3 Every trust should have a defined personality disorder pathway with a stepped care approach, with clear lines of referral and criteria at each level and a copy of the model should be available in print for prospective patients to see as well as staff. Suitable pathways should also be available in CAMHS; details are beyond the scope of this document.
- 4.4.4 Every trust should provide support for carers/family and friends of those with personality disorder and access to family therapy where appropriate.
- 4.4.5 24/7 crisis teams need to be available for adults and CAMHS, and suitably trained, supervised and supported for work with personality disorders.

4.5 Tier 4:

These are specialist provisions for personality disorders, with suitable therapeutic environments. This requires a specific way of working, and training of staff, that is different to mainstream psychiatric provision.

- 4.5.1 Each Sustainability and Transformation Plan area should have access to specialist residential therapeutic units for personality disorder for those who have not been able to make sufficient use of Tier 3 interventions.
- 4.5.2 When residential services are required, these are delivered with a shared care model with local (Tier 2 or Tier 3) services.
- 4.5.3 Programmes should deliver an integrated programme of milieu and psychosocial interventions incorporating the whole service (patients and staff) as therapeutic agents.
- 4.5.4 Tier 4 interventions should be considered in consultation with Tier 2 and/or Tier 3 services and entry into the service planned with the local team and negotiated with the patient.
- 4.5.5 Preparation for admission to residential services should include a psychosocial programme for community step down.
- 4.5.6 Tier 4 service provision should include patients detained under mental health legislation, as well as informal patients.

- 4.5.7 Specialist Tier 4 services should offer flexible but time-limited programmes which may be arranged in phases to facilitate the process from engagement and assessment to rehabilitation, discharge and recovery.
- 4.5.8 Length of treatment can be shortened or lengthened as evidence of treatment responsiveness and safety emerges.
- 4.5.9 Services offering different modalities across a pathway should work flexibly to accommodate movement from service to service.

4.6 Secure hospital and community forensic provision (Tier 5 and 6):

- 4.6.1 Pathway should encompass a network of specialist provision from high, medium and low secure hospital units such that patients can pass between them whilst maintaining work toward therapeutic goals.
- 4.6.2 Programmes should deliver an integrated programme of relevant evidence-based interventions within a therapeutic milieu which enables appropriate incorporation of physical, procedural and relational security into the therapy.
- 4.6.3 Services should be integrated with the Offender Personality Disorder Programme.
- 4.6.4 Community forensic mental health services must ensure that there is appropriate provision for those with and without convictions who pose a significant risk to others if untreated, who no longer need to be in hospital but who are not ready for primary or secondary care alone. Community forensic mental health services may also have an important consultation-liaison role with the latter and with criminal justice services.

4.7 Transition from child and adolescent mental health services (CAMHS):

- 4.7.1 Local CAMHS should ensure there is a range of outpatient interventions for patients with emerging personality disorders available on an outpatient basis.
- 4.7.2 Local CAMHS should ensure there is support available. This will be for parents and carers of those with personality disorder as well as offering consultation to adult services who are working with people with personality disorders who have children.
- 4.7.3 Tier 3 and 4 CAMHS should identify patients making frequent and lengthy use of acute and crisis care and provide them with specialist interventions that deliver an integrated programme of milieu and psychosocial interventions incorporating the whole service as therapeutic agent. Acute and crisis care services must have seamless pathways to ensure that, where children and young people are seen out of hours, CAMHS are informed of the assessments. Often inpatient treatment is unhelpful for such young people who may be prone to developing dependency on inpatient services and may increase their risk, making them hard to discharge. Admissions, when necessary, should be short crisis admissions, and

these need to be available for children and young people, as well as adults. Good crisis services and evidence-based community provisions such as outpatient DBT teams can minimise unhelpful inpatient admissions.

- 4.7.4 For a small minority of patients who make very frequent use of inpatient services, pose ongoing high risks and/or are difficult to discharge from hospital, therapeutic low secure services and specialist community-based residential services should be available (akin to adult Tier 4 provision).
- 4.7.5 Expert assessment and planning of the move to adult services is required in preparing for the transition, at whatever age it happens. This process may be enhanced by developing transition leads within adult services who can ensure that referrals are picked up by adult services in a timely fashion.
- 4.7.6 A delay in transfer to adult services may be considered for those patients who are unlikely to require crisis or acute care and who are well engaged within a therapeutic programme where resources allow for this. Similarly, in some cases where the young person's needs will be best met by existing adult provision, transfer to adult services in advance of a young person's 18th birthday should be considered.

4.8 Perinatal and infant mental health services

This is an important area, including in relation to prevention and safeguarding, for which this position statement is only a starting point. More detailed work is being undertaken by the CAMHS Faculty, and publication is anticipated to follow this document.

- 4.8.1 Perinatal services should ensure that there is a range of attachment-focused outpatient interventions available for mothers with personality disorder.
- 4.8.2 Perinatal services should have the option of co-working with specialist local services when more specialist treatment needs are evident.
- 4.8.3 Services for mothers diagnosable with personality disorder are needed, including for those who have one or more children taken into local authority care.
- 4.8.4 Young carers, who look after siblings or parents, for reasons of parental ill-health, need consideration and suitable care for themselves.

Appendix 1

Current guidance

The recommendations in this paper are informed by the following publications:

- 2003: Department of Health Policy Implementation Guide. Personality Disorder: No Longer a Diagnosis of Exclusion. (National Institute for Mental Health in England, 2003)
- 2003: Department of Health: *Breaking the Cycle of Rejection*. Workforce development strategy (NIMHE, 2003)
- 2009: NICE Guidance: CG78, *Borderline personality disorder, recognition and management* (NICE, 2009)
- 2009: NICE Guidance: CG79, *Antisocial personality disorder, recognition and management* (NICE, 2009)
- 2009: Department of Health: *Recognising complexity. Commissioning guidance for personality disorder services* (Department of Health, 2009)
- 2009: Ministry of Justice: *The Bradley Report: Review of people with mental health problems or learning disabilities in the criminal justice system* (Bradley, 2009)
- 2011: Ministry of Justice: *Working with personality disordered offenders. A practitioner guide* (National Offender Management System, 2011)
- 2013: NICE Quality Standards: QS34: *Self-harm*
- 2014: Department of Health: *Meeting the Challenge, Making a Difference. Working effectively to support people with personality disorder in the community. A practitioner guide for front-line staff* (Bolton et al, 2014)
- 2015: NICE Quality Standards: QS88, *Personality disorders, borderline and antisocial* (NICE, 2015)
- 2016: NICE Quality Standards: QS140, *Transition from children's to adults' services* (NICE, 2016)
- 2018: Healthcare Quality Improvement Partnership (HQIP) National Confidential Inquiry. *Safer Care for Patients with Personality Disorder* (National Conference Inquiry, 2018)
- 2018: Personality Disorder in Scotland Report: *Raising awareness, raising expectations, raising hope* (RCPsych, 2018)
- 2018: *"Shining lights in dark corners of people's lives"* The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder (Mind and others, 2018)

Appendix 2

Evidence base

Since 2000, the evidence base has grown considerably. Outcome studies of single treatment modalities are covered by the NICE guidelines, referenced above. This section covers other salient findings.

Epidemiology of personality disorder and the burden to public health (Evans et al, 2017) on prevalence:

- Community prevalence: 4.4%
- 24% to 28% of primary care attendees
- 33% to 52% in psychiatric outpatients
- 40% in eating disorders, 53% in substance misuse
- 63% in somatisation disorder (medically unexplained symptoms)
- 50% in inpatient services
- Up to 80% prison population

Lifelong outcomes for people diagnosed with personality disorder (Evans et al, 2017)

- 17.7 years of life lost for men
- 18.7 years of life lost for women
- 45% presenting to A&E with self-harm have personality disorder
- Doubles the risk of 'poor outcome' in depression and anxiety disorders
- Doubles the risk of 'high use' inpatient services

Personality disorder and suicide

- 9–10% of people with personality disorder will die by suicide (Paris, 2002)
- Between 45 and 77% of people who die by suicide have personality disorders (Cheng et al, 2000)

Economic burden from personality disorder (Meuldijk et al, 2017)

- Mean annual cost (across all sectors, excluding specialist treatment) = €11,126 (Soeteman et al, 2008)
- Assuming prevalence = 4.4%, total cost to UK economy = €35bn

Personality disorder and offending

Multiple incidences of violence in forensic setting (Freestone et al, 2013)

- Five times more likely with borderline personality disorder, compared to no personality disorder
- Eight times more likely with dissocial personality disorder, compared to no personality disorder
- 25 times more likely with both, compared to no personality disorder

Incidences of serious violence (causing injury) in forensic setting (Freestone et al (2013)

- 3.5 times more likely with borderline personality disorder, compared to no personality disorder
- 10 times more likely with dissocial personality disorder, compared to no personality disorder
- 20 times more likely with both, compared to no personality disorder

Intergenerational implications

Maternal personality disorder

- Twice the risk of postnatal depression (Hudson et al, 2017)
- Three times the risk of postnatal anxiety (Hudson et al, 2017)
- 2.27 times the risk of depression and self-harming behaviours in young people (Pearson et al, 2018)
- 50% of children with conduct disorder have a parent with personality disorder (Bonin et al, 2011)
- Interventions for their parents produced savings in a ratio of 8:1 (Bonin et al, 2011)

24% of care proceedings are repeat proceedings where the prevalence of personality disorder among the parents is very high (Broadhurst et al, 2015; Broadhurst et al, 2017). It is widely recognised that care proceedings are increasingly culminating in children being taken into care. The figure for England and Wales in 2017 was 72,760. There has been a 140% increase in the number of child protection referrals in the past decade (Broadhurst et al, 2017).

Personality disorder pilot projects – qualitative findings

In the final stages of the National Personality Disorder Programme, the Department of Health commissioned a qualitative evaluation of the NIMHE pilot personality disorder service projects, called Innovation in Action (Regional Care Pathway for Personality Disorders in Northern Ireland, 2014). Its main findings were:

Services designed specifically for personality disorder show:

- Human and economic cost savings
- Prevention of continuing harm and deterioration of conditions
- Improved level of employment and work-related activities
- Repeat crisis presentations halted
- Improved quality of life
- Establishment of recovery communities and building of social capital

Required therapeutic characteristics:

- Therapeutic environment
- Service culture and therapeutic philosophy
- Reciprocal investment by staff and service users with shared experience

Intermediate qualitative findings:

- Improved quality of relationships and effective sense of personal agency
- Use of social resources
- Experience of psychological safety

Service characteristics:

- Organisational and recruitment characteristics are important for service success
- No specific model amongst those reviewed emerged as superior
- Services demonstrating greatest provision of, and commitment to, the fundamental assumptions and general therapeutic conditions appeared to demonstrate the most significant outcomes

Appendix 3

History of service developments

Before 2000, personality disorder was under-recognised as a serious psychiatric problem (Warden, 1998) outside forensic mental health services (Maden, 2007) and a small number of specialist units (Norton & Hinshelwood, 1996). These disorders were seen as a difficult area of practice with limited hope of therapeutic success (Lewis & Appleby, 1988; Chartonas et al, 2017; Day et al, 2018), although recent work has shown signs of progress (Since 2000, an English policy initiative and an international research effort have led to rapid development of the field).

In 2003 the National Institute of Mental Health published *Personality Disorder: No Longer a Diagnosis of Exclusion*. This highlighted the variability in practice and provision and the high levels of institutionalised stigmatisation which explicitly barred patients with personality disorder from services. The paper quoted a survey conducted in 2002 which cited 17% of trusts as having a dedicated personality disorder service with 40% providing “some level” of service. 28% said they had no service and 25% did not respond. *No Longer a Diagnosis of Exclusion* launched the national Personality Disorder Programme (2003 to 2011) which brought coordination and leadership across government departments and a coordinated effort to develop services in health, criminal justice, education and social care.

The programme funded 16 NHS pilot projects with independent evaluation alongside a three-level national training programme. The pilot projects were co-commissioned and co-designed with service users (Haigh, 2007) and were designed to investigate a variety of service models and treatment approaches.

The results of the independent evaluation, *Learning the Lessons*, were reported in 2008 (Crawford et al, 2007). 2009 saw the publication of *Recognising Complexity* (Department of Health, 2009), a comprehensive commissioning guide for personality disorder, and the publication of two NICE treatment guidelines: one for borderline personality disorder (NICE, 2009) and one for antisocial personality disorder (NICE, 2009). The Knowledge and Understanding Framework (KUF) programme has now trained more than 100,000 frontline staff, patients and carers at ‘awareness level’, BSc and MSc across the UK (Davies et al, 2014). All elements of the programme were co-produced with Emergence (the national service user-led organisation), the Tavistock Clinic, the Open University and Nottingham University’s Institute for Mental Health.

In 2008, the Bradley Report recognised the need for a public health approach to the care and treatment of offenders; following this, the Dangerous and Severe Personality Disorder (DSPD) programme evolved into the Offender Personality Disorder Pathway (Joseph & Benefield, 2012). Its joint work, between NHS England and the National Prison and Probation Service, continues and has led to the establishment of Enabling Environments and Psychologically Informed Planned Environments in over 200 English prison and probation facilities (Rawlings & Haigh, 2016). Following the economic downturn, the community programme for services in non-forensic settings (Rawlings & Haigh, 2016) ended; its final publications were a practitioner guide *Meeting the Challenge, Making a Difference* (Bolton et al, 2014) and a comprehensive report into the eleven pilot services,

Innovation in Action (Wilson & Haigh, 2011). Since then, strategic drift has led to patchy provision and variability in what is provided to whom.

In 2014 the National Personality Disorder Service Survey Review Group was formed and it conducted an extensive survey in 2015 (Dale et al, 2017). With a 91% response rate across England, the group found that all trusts reported offering a service for people diagnosed with personality disorder either through generic or specialist services. 84% indicated at least one dedicated service although these varied considerably in task, reach and resourcing. Only 55% of respondents reported offering equal access to such services within their localities. The survey has since been repeated in Wales and most recently Scotland¹ with similar findings.

Despite this increase in the number of services stating they provide for patients with personality disorder, the experiences of service users, expert opinion and professional groups all point to continued marginalisation and deficiencies in provision. These concerns are described in the *Personality Disorder Consensus Statement* which had a parliamentary launch in January 2018 (Lamb et al, 2018; Easton, 2018). Chaired by Norman Lamb MP and expert-by-experience Sue Sibbald, the statement drew together the experiences of service users and carers, the opinions of experts and the views of the different professional bodies. The statement painted a critical picture of continuing marginalisation, with an incoherent strategy at local and national levels and inadequate resourcing leading to inefficiencies and iatrogenic harm. These concerns have been given further weight by the publication of *Safer Care for Patients with Personality Disorder* by the National Confidential Inquiry into Suicide and Homicide (National Confidential Inquiry, 2018).

Appendix 4

Next steps:

1. Evaluating this guidance

As local services and nationally coordinated strategies develop, relevant statutory agencies and individuals will be asked to participate in evaluation of how this guidance is being implemented. This will include NHS Mental Health Trusts, local CCGs, NHSE specialist commissioners, accountable care organisations and service user groups.

The following questions will be included:

- Who is leading the development of personality disorder services in your area and who employs them?
- How do they coordinate their work within and beyond the health sector?
- At what level have strategic approaches to personality disorder service development been agreed by stakeholder organisations?
- At what level have strategic approaches to personality disorder staff training and workforce development been agreed by stakeholder organisations?
- At what level have strategic approaches to formal research in this field been agreed by stakeholder organisations?

2. Further development of RCPsych guidance in this area

The College, through its faculties and other professional structures, should consider this position statement as the beginning of a comprehensive process to recognise and address the problems of people diagnosable with personality disorder.

This might entail further cross-faculty initiatives, those solely relevant to individual faculties, or work with other departments of the College. Examples of work that could usefully follow this document include:

- Specific and detailed considerations for children and young people's services
- Appropriate use of the Mental Health Act, and forensic considerations
- Recommendations for research priorities
- Quality standards for Tier 3 and Tier 4 services
- Instigating suitable training for specialist and general psychiatrists in the field.
- Reviewing the impact of the diagnostic label, and consider alternative approaches, with key stakeholders.

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