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WELCOME

Welcome to the 37th edition of the Quality Network for Forensic Mental Health Services' newsletter on **'Personality Disorder and Effective Treatment Pathways'**. We have been inundated with fantastic articles from a variety of sources, including service-users, member services and relevant organisations. We are so grateful for all your hard work and effort in contributing to this edition!

Since last writing, we have been busy facilitating the review days, conducting reviewer training and hosting two events. Firstly, NHS England's Launch of the Carers' Toolkit for Secure Mental Health Services took place on 27 March 2018. It was a very successful event with delegates hearing from a number of individuals that support loved ones in secure care.

The following week, on 4 April 2018, we also hosted our first patient-led event, 'Patient Engagement and Involvement in Secure Services', in Leeds. Chaired and delivered by



the QNFMHS patient reviewers, the day consisted of recovery stories, interactive tasks and good practice workshops. Around 150 people were in attendance, including almost 50 patients. Thank you for sharing the day with us, we hope you enjoyed it as much as we did! Over the next few months, we will be preparing for the MSU Annual Forum on 22 May 2018 and the LSU Annual Forum on 12 June 2018. We are currently calling for workshop and poster presentation proposals. We look forward to seeing you all there!

Dr Quazi Haque and Megan Georgiou

Her Majesty's Prison and Probation Service (HMPPS)

The Offender Personality Disorder Programme

The joint NHS and HMPPS Offender Personality Disorder (OPD) strategy was launched in 2011. The new strategy announced the ambitious intention of using the same level of resources that were deployed in the earlier Dangerous & Severe Personality Disorder (DSPD) pilots to provide improved and earlier identification and assessment of offenders who might satisfy a diagnosis of 'personality disorder,' and many more treatment and progression places in prisons, approved premises and in the community. Now seven years into implementation, the OPD programme has identified over 30,000 offenders who are in scope, employs an estimated 2,000 people, and has tripled the number of available treatment places. We are particularly proud of the way that our 'jointness' – in the way the programme is funded, commissioned and delivered jointly by the NHS and HMPPS – is becoming embedded at all levels, and how the pathway is becoming an increasingly well-established part of the health and criminal justice landscape.

The overall aim of the OPD programme is to improve public protection and psychological health. **It is a cross-sector, collaborative, evidence-based, community-to-community pathway approach** that provides motivation and engagement, treatment, and support post-treatment. The key principles underpinning the programme are that offenders who might satisfy a diagnosis of 'personality disorder' (or complex interpersonal problems arising from psychological, behaviour and emotional difficulties) are a shared responsibility of HMPPS and the NHS, and that planning and delivery is based on a whole systems approach across the criminal justice and health systems. Treatment and management is psychologically informed and led by psychologically trained staff in HMPPS and

the NHS, focusing on relationships and the social context in which people live.

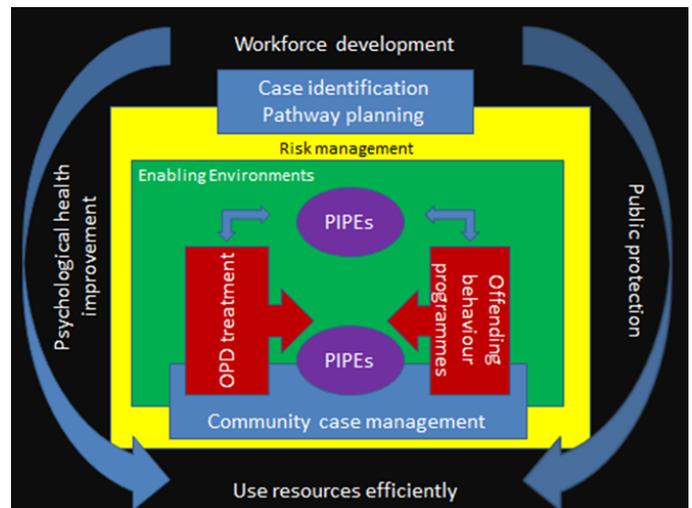
The pathway begins with **Case Identification**. We aim to identify offenders who fit the criteria at the earliest stage after sentence. The criteria for men and women are different due to their different needs, presentations, and behaviour:

Men and women:

- Likely to have a severe 'personality disorder;'
- A clinically justifiable link between the 'personality disorder' and the risk; and
- The case is managed by NPS.

Additional criterion for men only:

At any point during their sentence, assessed as presenting a high likelihood of violent or sexual offence repetition and as presenting a high or very high risk of serious harm to others.



Once individuals have been identified for the pathway, the offender manager works with a health partner to develop a **Pathway Plan** for each offender based on a process of **Case Consultation and Formulation**. This describes a process of specialist advice and discussion between the health partner and the offender manager to consider the offender's psychosocial and criminogenic needs relating to their interpersonal problems.

Depending on the plan for the offender, he or she may engage in suitable HMPPS accredited behaviour programmes, or in **OPD treatment**, which is now available in prison, hospital and community settings. OPD treatment services aim to ensure an improvement in mental and emotional wellbeing, social circumstances, and community ties associated with the reduction in risk of reoffending. They deliver an evidence-based service within a safe, supportive and respectful environment (quality assured through achievement of the Royal College of Psychiatrists' Enabling Environments award), employing a range of skilled, motivated, supported and multi-disciplinary staff to address offenders' interpersonal difficulties and behaviours.

One example of an OPD treatment service is the **Nexus service for women at HMP&YOI Eastwood Park**. Delivered jointly by the prison and Avon & Wiltshire Mental Health Partnership NHS Trust, Nexus offers a total of 30 treatment places, on a residential, day-care and outreach basis. The therapeutic approach offered is based on an attachment model of care. A phased approach begins with pre-treatment activities (psycho-education, crisis management planning and motivational work), moving to stabilisation, and progressing to trauma-focused work. Another example is the **FIPTS service**. Delivered jointly by South London & Maudsley NHS Foundation Trust and Penrose housing, together with the National Probation Service London Division, this community-based service is primarily focused on intensive risk management, but it also provides group and individual treatment, and for some service users, supported housing. Therapies include psycho-education, Dialectical Behaviour Therapy and the Violence Reduction Programme. The social component of treatment involves assisting with education, vocational or employment opportunities, benefits, and managing service users' physical health.

Psychologically Informed Planned Environments (PIPEs) are probably the

best known output of the OPD strategy. PIPEs are not a treatment; they are instead designed to enable offenders to progress through a pathway of intervention, supporting transition and personal development at significant stages of their pathway, either in prison or in approved premises. There are now 23 PIPEs nationally – 14 in prisons and seven in approved premises.

All available OPD services are summarised in the brochures of OPD Services (one for male services and one for female services), available on request from pd@noms.gsi.gov.uk.

As a developmental programme, we have a strong emphasis on three further areas of work: firstly, **workforce development**, equipping staff across the offender pathway with the right skills and attitudes to work with this group of high-risk offenders; secondly, **involvement**, taking account of the experiences and perceptions of offenders and staff at the different stages of the pathway; and thirdly **research and evaluation**, with a number of projects underway, including NEON, the national, independent evaluation of the OPD pathway, which will include an assessment of whether the new arrangements offer value for money and is due to report in 2019.



Mural at the PIPE, HMP Swaleside

Implementing the OPD strategy has not been without problems. Engagement with this client group can be difficult and there remains a lack of definitive evidence about treatment effectiveness. From a systems perspective, the difficulties are around bringing together two independent organisations, HMPPS and the NHS, both with different cultures and systems and both requiring independently and together to

embed new ways of delivering services. What unifies them is the client group who require the help and support of both systems together, and the compelling need to deliver more effective public protection.

Sarah Skett, NHS England Joint Head, OPD Programme Team; Laura d’Cruz, HMPPS Senior Co-Commissioning Manager, OPD Programme Team

South London and Maudsley NHS Foundation Trust

My Thoughts

It now seems like many years ago that I was in a prison and was told that maybe, I should have been in a hospital as I had some form of personality problems. And so, I found myself being transferred from prison to the Bethlem Royal Hospital, River House. After 3 days, I was not sure what was going to happen and asked the Doctor if I could go back. He said: ‘no’. Looking back, I am quite glad he said that and so I found myself doing ‘Understanding Personality Disorder’ and finding what cluster I fell in to. Also, around this time, I was diagnosed with schizotypal, borderline, and schizoid personality disorder.

So now I had some labels and I was to start the violence reduction programme, which was dragged out over two years (it seemed). Cognitive distortions, schemas, emotions, smart goals, defence mechanisms. I have been here, at the Bethlem Royal Hospital, for over five years now, but for me it seems only a short time.

After waiting for 15 months for ground leave, the first ½ hour was the most amazing and worthwhile, as I had waited for over 10 years just to touch a tree, feel the bark, wonder at its branches, which seemed to be gently waving their leaves at me in the breeze. To walk on grass, with moss mixed in with the grass making it feel nice and springy. To be able to walk in a straight line for more than 25 meters. To stop in a

puddle, to be able to walk further than 50 yards within the confines of walls and fences, to see other people’s cars.

For now, the grounds are almost my home, as I spend more time on them than anywhere else. Every time I go onto the grounds, there is always something different to see, as the seasons are forever changing, bringing untold mysteries, the wind that answers my lost thoughts, emotions and feelings.



Though the squirrels can't talk, they are good to talk to sometimes. The birds come, sit by me and sing a tune to me; foxes come and play within sight of me, as if I was just part of the scenery. You could spend hours just sitting under a tree, watching the clouds drift past, and not see a single person. And if you were to feel down, there are always dog walkers around, for just to see a dog wagging its tail is sure to bring a smile to you.

On a new ward, still within Bethlem Royal Hospital, but now I had a window through which I could see the outside world. I spent a whole evening watching the buses going up and down the road, which was novel. I was to stay on this ward for another 2-and-a-half years.

Staff got me to teach other staff about My Shared Pathway, a selection of documents that encourage better communication between staff and service users, which I have been doing now for over three years. Now that I have been relaxed (three weeks ago), I find some things totally different and some just the same.

After three months, I was able to go to woodwork and made myself a stereo cabinet, bedside cupboard, and a small chest of drawers, all of which I still have with me. My first trip to the outside world, or the community, was different. One escort hovered over me in a shop with her arms folded at one end of the shop and the store security guard at the other, it is not much fun. Having the electronic buddy falling off as you go into a shop, but if I got on a bus full of kids, I was always sure to get a seat with it on display.

Some months later (8) I was allowed out on my own, then after that the electronic device was taken off and I was to get used to travelling around by myself. There were times when I would stand by the road and watch the buses and still think of throwing myself under the wheels. But after so much effort and help from others, would I achieve anything by doing this? I have found that others will not be able to help you if you do not tell them what is going on, so you have to communicate to people!

Matthew, Service User, River House

Health Service Executive

Language, Stigma and the Borderline Personality Disorder Label

'Language is power, life and the instrument of culture, the instrument of domination and liberation' – Angela Carter (1998).

Those who experience complex human distress and present with problems of emotional dysregulation, impulsivity and social-interpersonal difficulties, are frequently labelled using the borderline personality disorder (BPD) diagnosis. The language that surrounds the BPD label is powerful, predominantly negative and

stigmatising in the extreme. It acts as an instrument of our culture, pathologising those who do not conform to social norms and expectations, particularly women. The 'borderline' label and language of personality 'disorder' is indicative of the dominance of the biomedical gaze that underpins mental health diagnoses. Borne out of DSM-III in the 1980s, the much-contested BPD diagnosis has survived as a diagnostic category in the 'psychiatric bible' that is the DSM. Mental health activists and proponents of the antipsychiatry movement, however, decry the use of the BPD label that medicalizes human distress and call mental health professionals to action to eradicate its use in contemporary mental health discourse. Feminist critiques identify BPD as a gendered diagnosis, since 75 percent of those given the diagnosis are women. It has

been suggested by feminist writers that symptoms attributed to BPD could be more helpfully understood as a survival strategy for traumatised women.

Leaving aside the debates that surround the construct validity of the BPD diagnosis, health professionals have a critical role in working with individuals diagnosed with BPD whether in a hospital, forensic setting, outpatient clinic, primary healthcare, or community setting. Further, within contemporary healthcare, as we move towards an era of trauma-informed practice, we must, as healthcare professionals, consider our role, attitudes, behaviours and crucially the language we use in respect of and when engaging with, individuals labelled as having BPD. While it is recognised that those living with any mental health diagnosis experience stigma, Heydari *et al.* (2017) damningly describe mental health stigma as a 'black shadow', the term 'surplus stigma' has been attributed to BPD (Hoffmann, 2005). No other diagnostic group routinely suffers such a level of prejudice as those given the BPD diagnosis. Consultant clinical psychologist, psychotherapist, media contributor, psychiatric survivor and activist Dr Jay Watts writes eloquently and passionately on the topic. As an activist, she strives to inform, educate, and radically change the perceptions, misconceptions and prejudices that surround the BPD label, which she points out serves as a kind of 'shorthand' between clinicians that singles out the individual as someone who is 'difficult' or 'troublesome', someone who might engender difficult responses in the clinician and who should, therefore, be avoided or kept at a distance.

Stigma associated with the BPD label is readily identifiable in the literature that examines the attitudes of mental health professionals towards individuals given that diagnosis. Individuals who are experiencing distress labelled as BPD are typically stereotyped as 'manipulative', 'attention-seeking', 'staff-splitting', 'needy', and

'dangerous'; language that is at once accusatory, and dismissive. Indeed, Bonnington and Rose, in their 2014 study, found that people labelled as having BPD endured two categories of stigma that arise from within the healthcare context; stigma related to diagnosis and the BPD label and stigma pursuant to negative staff attitudes. It is further evident in the literature, and in practice, that while pockets of excellence exist in the provision of appropriate, trauma-informed care for individuals in distress, regardless of their diagnosis, many mental health professionals continue to demonstrate prejudice, discrimination and low levels of empathy towards individuals labelled as having BPD. Furthermore, in order to combat negative stereotypes, it is important to consider the language we use as professionals working with those who have been given a BPD diagnosis and how negative and unhelpful language contributes to the stigma, prejudice and discrimination commonly experienced.

Dr Watts persistently calls for a new language, together with a new social understanding around how and why individuals arrive at a crisis point, what contributes to their distress, and ways in which mental health services inflict harm. The author here echoes her call for a new 'consciousness-raising and language-generating' process around the concepts of distress and complex trauma from within the mental health arena. This new language will evolve for individuals labelled as the 'instrument of liberation', alluded to by Carter in the opening quotation. We, as mental health professionals, can help by moving away from the exalted position of 'expert', by rejecting the BPD diagnosis and pathologisation of distress and by first 'doing no harm' with the language that we use in the name of care.

Teresa McDonagh, Staff Nurse, Central Mental Hospital

Nottinghamshire Healthcare NHS Foundation Trust

Arnold Lodge Personality Disorder Service New Model of Care: Meeting the Needs of Patients and Affecting Therapeutic Change

Arnold Lodge Medium Secure Unit in Leicester first opened a dedicated service for offenders with personality disorder (PD) in 1999. At that time, the service offered a cognitive-behavioural based programme for sentenced prisoners with a diagnosis of PD,

who were motivated to change. In 2007, a second PD ward was commissioned to offer intensive rehabilitation to patients stepping down from high secure care.

However, mainly due to changes in service provision for patients with PD in the criminal justice system, those who are now referred for hospital-based care in our service have tended to be less motivated, more complex, and have histories of poor progress with other interventions. This required the service to reassess its model of care in order to meet the needs of this change, and a new service model was introduced in 2016. This is shown in figure 1 below.

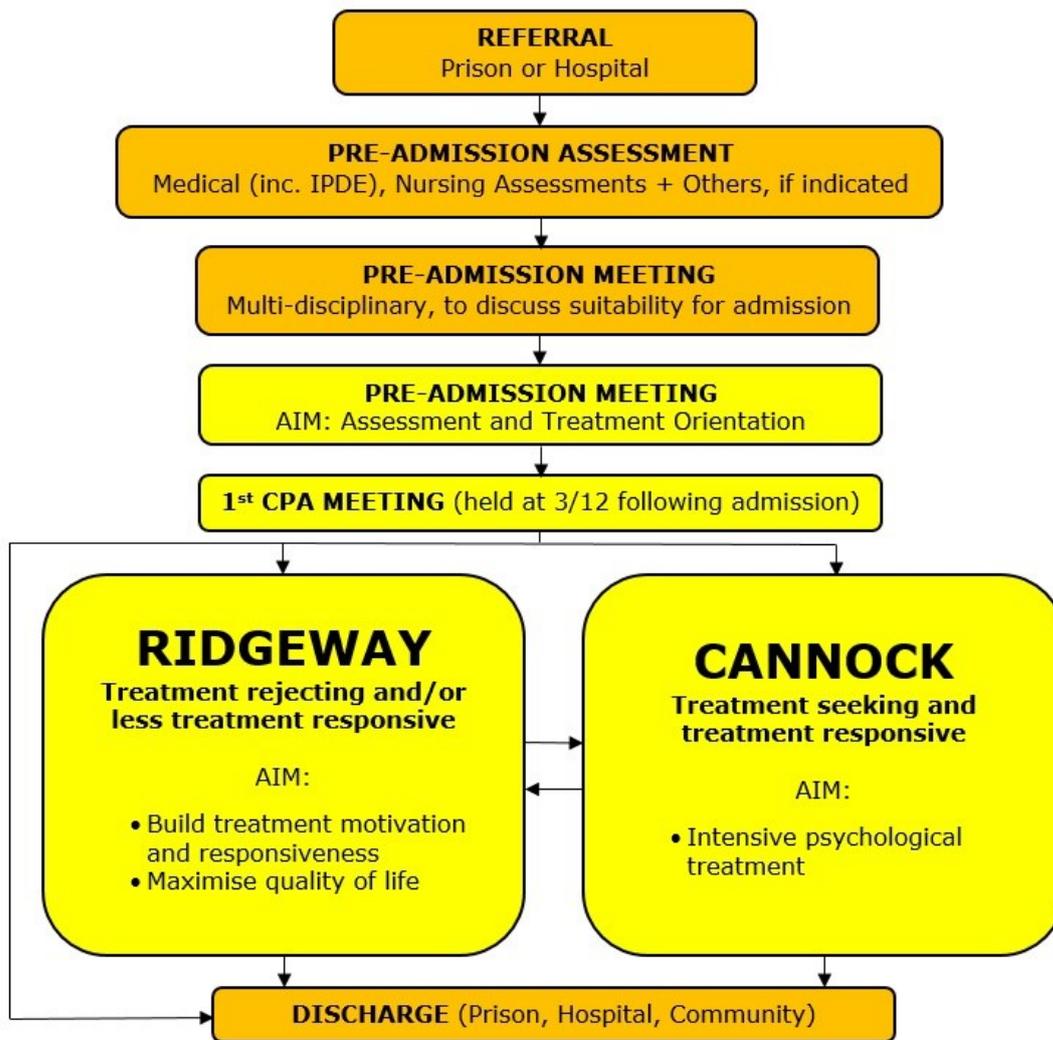


Figure 1 – Service model of care pathway in the PD service at Arnold Lodge.

Milieu Therapy



Figure 2. Personality Disorder Service Treatment Groups

Patients admitted to the PD service have access to a wide range of psychological and therapeutic groups that complement the milieu therapy of the wards (see Figure 2). Progress is assessed at the patients' regular Care Programme Approach (CPA) reviews and includes a review of psychometric assessments linked to specific treatment groups.

As the Arnold Lodge PD service has maintained an academic research service that runs alongside clinical provision, it has been possible, with patient consent, to build up a database of psychometric data from admission to discharge. Validated psychometric assessments used in the PD service include the Social Problem Solving Inventory-Revised (SPSI-R, D'Zurilla et al., 1995); the State-Trait Anger Expression Inventory-2 (STAXI-2, Spielberger, 2000) and the Psychological Inventory of Criminal Thinking Styles (PICTS, Walters, 1995).

For example, cross-sectional analysis of the Social Problem-Solving Inventory-Revised (SPSI-R, D'Zurilla et al., 1995) subscales has demonstrated an increase in patient scores over time for measures of constructive problem solving (e.g. Positive Problem Orientation, Rational Problem Solving, and Total SPSI score; higher score = better). Analysis has also shown that measures of dysfunctional problem solving (e.g. Negative Problem Orientation, Impulsivity/Carelessness Style, and Avoidance Style; lower scores = better) decrease over time.

Evidence from the psychometric assessments provide some indication of change occurring through treatment; however, the mechanism by which change occurs is unclear. Building on the work of Wilmot and McMurrin (2013; 2014), a recent MSc project conducted by Hay (2015) asked patients in the Arnold Lodge PD service to think about a) the aspects of their personality that changed as a result of

psychological therapy, and b) the mechanisms underpinning therapeutic change. Patients described the following mechanisms of change: learning to understand the self (e.g. understanding negative self; recognising the need for change); opportunities to learn (e.g. value of learning from negative events; value of feedback); the importance of supportive 'others' (importance of staff, peers and family); and the therapeutic features of the hospital.

It is acknowledged that the evidence base for effective treatments for personality

disorders in general, and antisocial personality disorder particularly, requires strengthening (Gibbon et al., 2009; Khalifa et al., 2010). However, it is the experience of the Arnold Lodge PD service that the provision of structured psychological interventions within a safe and therapeutic milieu is able to influence positive change for many patients.

Dr Lucy McCarthy, Senior Research Fellow; Dr Simon Gibbon, Consultant Forensic Psychiatrist and Dr Penny Banerjee, Consultant Forensic Psychiatrist, Arnold Lodge

Birmingham and Solihull Mental Health Foundation Trust

My Experience of Personality Disorder and How Professionals Can Help

I am a service user in a medium secure unit called the Tamarind Centre, which is in Birmingham, West Midlands. I live on Laurel, which is a specialist ward treating 12 service users for a range of complex personality disorders.

Living with personality disorder (PD) has been very difficult to accept and understand. At first I struggled to understand why someone would be told they have a PD and it wasn't just one's personality. After lots of psychological treatment, I've come to understand the difference between personality and PD. It is when aspects of your personality and the behaviours you exhibit become problematic for yourself and people around you on a regular basis. After coming to understand what the diagnosis meant, I then had to come to terms with it and accept that there was a problem in order for my psychological treatment to be effective. This was difficult, as I've always heard of PD as being spoken

about in negative and stereotypical ways. My early experiences in life (of which I had no control over as I was a child), have led me to develop a disorder and be detained under the Mental Health Act.

The nurturing process of a child's life is crucial in how we determine the way we relate to others, the environment we are in and how we present ourselves in later life. Early attachments are crucial and failure to develop one or more secure attachments will make the child struggle in interpersonal relationships in adulthood and hinder them greatly in the future.

As a child, my initial caregivers and people in my immediate environment tended to be very critical. Due to these experiences, I developed schemas – such as fear of being criticised. A schema is a subconscious belief about one's self that when triggered will evoke very intense feelings and emotions, often resulting in negative behaviour. As a result, I have developed compulsive behaviours which helped me regain a sense of control in situations where I felt out of control, the way I would have felt as a child when being criticised. I still feel this way when I feel someone is being critical. The compulsive safety behaviour I developed was to both mirror and project how I was feeling

onto the other person in order for them to feel the same way and to regain control. This is one example of a behaviour which I exhibit due to what I endured as a child.

As a result of these experiences, I struggle greatly in relationships. As mentioned earlier, I am now detained under the Mental Health Act in hospital. I feel as though people in the system stereotype people with a diagnosis of PD, which again makes me feel very criticised- taking me back to the way I felt as a child and triggering my schemas of fear of being criticised. I feel as though the stigma around PD is down to a lack of education and understanding around the illness. If people understood the origins of the behaviours of people with PD and the ways in which someone with PD is affected by how they are viewed and treated by professionals in the system, then treatment and recovery would improve.

If for instance, I behaved in a way that was associated with my disorder, then I shouldn't automatically be told I was being problematic and impulsive. I agree the

behaviour may be problematic but compulsive rather than impulsive, as it has a safety element and is keeping me safe, as it did as a child at times when I felt someone was being critical towards me.

I feel if there were greater understanding around the illness as there is for other types of mental illness, then the stigma would slowly start to fade, and treatment would become more effective for service users. If professionals at ward level were able to understand and be as educated about PD as they are for other types of mental illness, they could help the service user recognise the thoughts that are associated to the behaviour, the feeling, the emotions and the physical sensations in a reflection session after the incident. Then they could slowly help the service user recognise these things before the behaviour is acted out, gradually changing these negative behaviours. I fully advocate education around the illness to help staff understand patient's individual needs and help recovery.

Service User, The Tamarind Centre

Birmingham & Solihull Mental Health Foundation Trust

What does a Diagnosis of Personality Disorder mean to Service Users in a Medium Secure Setting?

For service users with persistent, pervasive and problematic interpersonal difficulties, the use of a diagnostic label can add much to support them live safer and more productive lives in several ways. Voices heard on the impact of diagnosis tend to come from professionals feeding back on behalf of service users or service users themselves. Less heard are the voices of those in acute settings, such as inpatient units, and

particularly those with the dual label of mentally ill offenders. As part of a service user voice project, service users from the forensic directorate were asked to identify what is helpful and unhelpful about having a Personality Disorder (PD) diagnosis and to explore their experiences of receiving and living with a diagnosis of PD.

Themes service users identified as helpful aspects of a diagnosis included:

- Improved Relationships
- Greater Understanding
- Treatment

Service users identified the impact of treatment and therapies in supporting them to recognise difficult aspects of their

personalities, which may be affecting how they interact with the world:

"Therapies help us to understand ourselves, why we are the way we are and why we behave the way we do."

"It is helpful because you can get support and therapy to live a normal life."

Another helpful aspect of the diagnosis for some was that it validated their experiences and helped explain previous behaviour to their family, leading to improved relationships:

"My family have a bit more patience with me having a disorder. People give me more time and understanding because they know how I am and that makes it more helpful."

Service users highlighted more difficult or unhelpful elements of their diagnosis, particularly stigma experienced due to judgement or a lack of understanding from others, difficulties in accepting the label or their experiences, and finally pitfalls in the treatment available.

All service users who responded, identified stigma as being an unhelpful aspect of their diagnosis:

"There is stigma around PD because you are seen as cunning and manipulative."

Service users recognised that this was possibly due to a lack of understanding from the public and professionals as to what a diagnosis means:

"I'm assumed to be schizophrenic because of multiple PD diagnoses. People are incorrect about you."

"A PD diagnosis is stigmatising, and some professionals think people are bad as opposed to mad, putting it bluntly."

Other service users identified a difficulty in accepting and understanding their own experiences:

"Waking up in a mood in the morning and not knowing why. Getting yourself together and knowing what's wrong and having to do what you've learned in therapy all the time to stay well."

"Having difficult relationships with people I'm close to. Being suspicious of them and thinking they're cheating on me and being used in the past."

Service users also identified a lack of provision in both secure and community mental health services for people with a diagnosis of PD, particularly those with a forensic history:

"It would be helpful if there was more community support for people with PD. It might help keep people out of hospital in the first place."

"Can be held back on pathway due to few beds – delays. Slower progression can make you agitated and bored, and it puts you on hold."

Although service users identified that a diagnosis can be helpful in increasing understanding and insight, as well as improving relationships with family, service users with a diagnosis of PD face significant difficulties caused by stigma, lack of understanding, and lack of specialist provision.

As part of the project, existing and potential ways to reduce and manage these difficulties were addressed, involving collaboration in developing resources and discussing with members of the multidisciplinary care team. Service users also suggested wider, strategic investment in supporting people with diagnoses of PD across healthcare systems.

**Natasha Harris, Assistant Psychologist;
Dr Edward Smith, Clinical Psychologist;
Lucy Courtney-Brisbane, Forensic Psychologist and Dr Ashley-Christopher Fallon, Clinical Forensic Psychologist,
The Tamarind Centre**

Experience of What a Personality Disorder Looks Like

I am not sure where this is going, am I looking in the mirror or through my own eyes at someone?

Where do I start? Being impulsive? Well I did read the poster properly today after seeing it several times in the corridor, so here I am in writing about it now. I do not even know why it is important that I do it, after all, what will I get out of it?

What about work? Being a workaholic, I can at least say I am sure I heard someone say, I just worked ninety-four days consecutive doing twelve hour shifts to see a project over the deadline. So what. More the fool you. Get yourself a life mate.

Still on being impulsive, I could be seductive and manipulating. I was in three separate relationships at the same time and living with each woman as if she was the only one. Falling in and out of love, leaving one for another, wondering who you want to spend Valentine's Day with. What about the other two? Are you working away that week and making phone calls only to them? Living in London, it is normal to have three relationships.

How about always having to be competitive and having ambitions before everything, with a strong drive to succeed and showing confidence all the time?

Emotions. What about lacking insight and empathy to other people's feelings, or how one's behaviour affects them? Showing signs of being unfaithful in marriage and even two, or three, committed relationships. How do you say the right things to people you could be hurting? Is it by having stock words and phrases so you know you're saying the right things, like following a film

script?

How do you show empathy? Do you tell the guy whose car broke down and he's late for work? Hope you make up the lost time, but it's not exactly my fault your car broke down.

When someone comes into work saying his Dad died, do you say sorry to hear that or are you thinking I hope he's not going to be off work too long? That will cause me problems. The people that don't meet up to your expectations are they just cast aside?

Being preoccupied with your own success and having no regard for others around you. I heard a girl working as a hotel receptionist one time talking saying you're the most arrogant and rudest man I've ever met. Was she taking time to check him in? He may have been going out on a date to see a new girlfriend after work and was in a hurry. Whose fault was that? He may have been working that day before checking in.

So is it okay to exploit your friends and co-workers for personal gain and can it all be about power and money or just showing what you can do with it. When you're travelling around the world and god knows who with, do you have to keep reminding those left behind about the affluent lifestyle you have afforded them?

When you miss family occasions do you just shower those people with expensive gifts and cards that don't really mean anything when you're having fun elsewhere? Is everything about you? Have you ever stopped and thought about what it is you're doing in life?

How many lives are you living? Have you ever asked the question why? Maybe it's you and success. Is that the real answer, or the one you need to hear?

Did I read that a man crashed a car twenty five years ago just to get out of a difficult relationship between two women at the

same time? What on earth was the problem of just saying "I'm leaving to one of them"? Maybe he didn't want to hurt either of them and thought a high speed crash into a bridge parapet was the solution, or what he was really thinking.

Is the truth distorted for personal gain and are you entitled to what you want when you want it no matter how you get it? The lavish lifestyle, fancy cars, houses, holidays, expensive taste and numerous women. Is

this really necessary and why can't you live without it?

The final question is does someone acting this way or even thinking this way end up being locked up?

Am I watching someone with a personality disorder or I have I just found out I may have one?

Service User, Ravenswood House

Birmingham & Solihull Mental Health Foundation Trust

Stigmatisation and the Use of Negative and Unhelpful Language Relating to Personality Disorder

Stigma is a social construct that defines people in terms of a distinguishing characteristic and devalues them as a consequence. The nature of forensic services places service users at particular risk of stigmatisation and there is a further risk of stigma for service users diagnosed with a Personality Disorder (PD). There are concerns that stigma can have a negative impact on service user recovery and experience.

As part of the recovery project within the forensic directorate, a group of service users drawn from the forensic directorate were invited to explore the impact language (i.e. specifically related to PD) has had on their recovery journey.

Service users identified that their experiences of accessing PD specific services had been positive, but they felt that people outside of PD services often viewed these services as the "dark side." Service users identified feelings of sadness, hurt and anger

that language of this nature was used, implying negative judgements about people with PD.

Service users discussed times when they had negative experiences of hearing people describing individuals with PD. This included the use of words such as "psycho", "manipulative", "cunning", "challenging" and "losers". Service users described feelings of anger and frustration at being labelled in this way. They felt that this type of language did not promote and enable recovery.

A service user shared his experience of having been told that he was "untreatable" due to having a diagnosis of PD. He said that this had left him with a sense of hopelessness and led him to question his recovery journey. He described experiencing thoughts such as "why am I here then?". The service user said that being given this message affected his willingness to engage with psychological treatment.

The discussions of the group noted that people with a diagnosis of PD often experience language directed at them, which they felt to be unhelpful and hurtful. It was discussed that in some cases, referral to specific personality disorder services could increase their perception of this by creating a sense of separation or otherness, although the benefits of having a supportive,

specialised environment were also discussed appreciatively.

The feedback of the service user group highlights how important the use of language is when both discussing personality disorder and deciding how services are described. Those working in and developing specialist services should consider the possibility of stigma being attached to these, being mindful of supporting positive staff attitudes and

including service users in decisions about how these services are promoted and described.

Clare Strickland, Assistant Psychologist; Dr Edward Smith, Clinical Psychologist; Lucy Courtney-Brisbane, Forensic Psychologist and Dr Ashley-Christopher Fallon, Clinical Forensic Psychologist, The Tamarind Centre



Woodwork completed by service users at the Tamarind Centre

The Royal College of Psychiatrists

Personality Disorder: Emotional Regulation is Not Enough

I first entered hospital when I was 35. It was a Cygnet Hospital and although my diagnosis wasn't one of PD, I was soon to learn a lot about it. Most other patients on the women's ward had been given a diagnosis of PD; specifically, borderline or 'emotionally unstable'. This was all new to me, who had never heard of the term before, let alone the associated behaviour of self-harm. I recall being very impressed by the Cygnet staff who seemed to know a lot about the diagnosis and even told me about the concerns about its validity and usefulness. A great many of the staff had been on a training course on DBT

(Dialectical Behavioural Therapy) in the U.S., and were preparing to run a DBT group on the ward for personality disorder. I was very intrigued about this; what was DBT, how did it help people with PD, and what on earth did 'dialectical' mean?

I wanted to attend the DBT group, to find out more, but was partially afraid to ask as I didn't have the relevant diagnosis. Fortunately, I was allowed, which helped me to feel the staff had a positive view of me, my needs and motivation. Although no one in the group seemed to be able to give a clear definition of 'dialectical', I was very interested to learn about 'mindfulness'; a technique which helped you to 'switch off' from repetitive stressful and distressing thoughts, and the various other forms of 'emotional regulation'. I thought it was great; there was nothing 'weird' or complicated about it; it sounded like common sense.

Emotional regulation is a very useful skill, regardless of whether you bear a label reading 'personality disorder' or not. It is particularly useful when you have another label; that of 'mentally disordered offender' assigned to you and you are detained on a medium secure ward, with minimal autonomy and purpose. To be in this situation is very unfortunate, to say the least. You have a mental disorder, need therapy and the opportunity to gain experiential expertise in the techniques you learn. You also desperately need to regain some positive and purposeful sense of self. Secure and forensic services unfortunately are not designed with the latter in mind. I was keen to test out my new awareness of 'emotional regulation' in the 'real world' beyond the 5.2 m high fences. My consultant was supportive and made the relevant application for escorted community leave to the MoJ. What followed was not a lot: the MoJ alternately claimed to have lost the paperwork, or to have answered the request, but had no record of doing so. It was a nightmare. Meanwhile, I was still stuck on the same ward, doing my best to apply my emotional regulation techniques, but, at the same time, sinking gradually ever deeper into a deep depression. Depression is a dreadful condition, it saps your motivation and fills every moment of conscious awareness with a cold, hard sense of dread. Even mindfulness does not help you to evade the pervasive feeling of pointlessness and silent agony.

Not that my fellow patients who had the PD

diagnosis seemed to fare any better. They had leave, would go out, return saying they'd had a great time, then self-harm and lose it all again. What was this alien condition they called 'borderline personality disorder'? Why did sufferers seek to hurt themselves? Why did they seek suffering when they were already unhappy? It all seemed very counter-intuitive, someone who, daily, was doing their best to avoid ending their life.

I once spoke to one of my fellow patients about the self-harm paradox, and she explained it in a way which made some sort of sense. For her, the act of cutting herself gave her a sense of achievement: 'there's nothing else to achieve on this ward, so I cut myself to feel as though I've actually done something with my day'. I was able to empathise with that. On secure wards, there is often very little, if any, opportunity to do something meaningful, other than perhaps 'colouring in' or making cup-cakes every now and then. Adults need a sense of responsibility and purpose; a reason to live. In the absence of this, even the most dedicated practitioner of emotional regulation can achieve little more than a bland sense of emptiness. Nature, and perhaps the mind too, abhors a vacuum, and will seek to fill it. Secure and forensic wards need to provide more than DBT and similar therapies; they need to provide hope, meaning and positive opportunity.

**Sarah Markham, Patient Reviewer,
QNFMHS**

Join the **Email Discussion Groups** to network with colleagues on topics relating to secure mental health.

Email 'join' to:
lsu@rcpsych.ac.uk
msu@rcpsych.ac.uk

**“Labels of PD and Offender
Camouflage me as a Man”:
How the Man Behind the
Mentally Disordered Offender
Label Seeks Greater
Consideration to Advance
Forensic Rehabilitation**

Male patients detained in the forensic mental health system comprise 86% of the population, with the majority of evidence-based rehabilitation programmes focusing on addressing mental health and offending. Despite this large proportion being male, the content and process of delivery does not routinely cater for gender-related characteristics. This is problematic, due to the known impact of men's experiences of trauma and poor engagement in intervention and how these can impede successful outcomes for services, men themselves, and public safety. Male service users diagnosed with PD report particularly noticing this, which is hypothesised as largely due to the reflective components of psychological therapies examining the historical origins of ongoing emotional and interpersonal difficulties, but also due to observations regarding the core areas of focus for services misaligning with service user experiences.

Our Forensic Directorate has been working on a male gender strategy focused on enhancing the effectiveness of clinical delivery with male forensic service users, initially developed with service users diagnosed with PD. Informed by the literature, clinical observations and the

voices of service users, the strategy continues to attract accumulating multidisciplinary and service user investment - positive early findings exist and the applicability to wider non-forensic work with men and boys exists also. Some of the findings highlight that, for every successful cohort of men with PD who have accessed and completed recommended programmes, there remain other significant cohorts whose rehabilitation is volatile and demand considering through a gendered lens. Some present a continued pattern of significant violence to self or others, others with personality, mental illness, and neuropsychological profiles that add further complexity. The workforce can struggle to identify and meet the needs of these groups and they either remain within services for extended durations, or risk being discharged to participate in cycles of psychiatric relapse or recidivism. Importantly, these men notice this failure and want to tackle it; however, gender-related barriers appear phenomenal to overcome.

The above short commentary acknowledges how the use of innovation is essential to expand upon the progress achieved by existing approaches to working with PD and in wider forensic mental health work. We welcome contact from colleagues working in other similar, but also unrelated services and would be keen to collaborate on sharing information and moving this area of PD work forward.

Dr Ashley-Christopher Fallon, Clinical Forensic Psychologist; Dr Kerry Clarke, Clinical Psychologist; Dr Sarah Bishop, Clinical Psychologist and Dr Anh Vien, Forensic Psychologist, The Tamarind Centre

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News



Mental Health Act: The rise in the use of the MHA to detain people in England

Mental Health Act

The rise in the use of the MHA to detain people in England

January 2018

This report looks at the causes for the rise in the use of the Mental Health Act (MHA) to detain people. In 2016, CQC worked with local services to gather views on the reasons for the national increase in the use of the MHA, this report demonstrates these findings.

http://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf



NHS England Service Specifications for Adult Secure Services

Service specifications are important in clearly defining the standards of care expected from organisations funded by NHS England to provide specialised care. The specifications have been developed by specialised clinicians, commissioners, expert patients and public health representatives to describe both core and developmental service standards.

<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c02/>

Funding and Staffing of NHS Mental Health Providers: Still Waiting for Parity

This briefing considers the current situation based on an analysis of the annual financial accounts of NHS mental health, acute and specialist provider trust, an analysis of the national workforce data, a review of the Care Quality Commission (CQC)

inspection reports for each of the 54 NHS mental health trusts and a review of the board papers of eight mental health trusts covering a six-month period from January 2016.

https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers?utm_source=twitter&utm_medium=social&utm_term=socialshare#funding-services-and-workforce

TheKingsFund

Ideas that change health care

Shaping policy and practice

Birmingham and Solihull Mental Health Foundation Trust

Using Process Mapping to Outline Service User Journeys From Admission to Discharge

Laurel is a twelve-bedded personality focused recovery ward in the Tamarind Centre within Birmingham and Solihull Mental Health Foundation Trust.

Some service users on Laurel ward had complained that they did not know what their care pathways were. This was despite the multi-disciplinary team believing the information was being communicated in a variety of ways, for example through the CPA review process, Mental Health Act Tribunal reports, and regular sessions between the service user and members of the team.

The original objective was to provide a visual representation of the service user's care pathway so staff and service users can reflect on it together; particularly to support service users' understanding.

As meetings took place between the multi-disciplinary team to map the pathway, it became clear that this was a useful resource for the team to reflect on their work with service users and relationships with one another; therefore, this became the second objective.

The initial process mapping exercise has been completed and was undertaken by the multi-disciplinary team. This involved discussions about the steps involved in the service user journey, using the SCALE model of care, which is the model of care for secure services within Birmingham and Solihull Mental Health Foundation Trust. Details of the steps involved in the care journey were mapped, and comments from the discussions were noted. The service had been open less than four years at the time that this work started, and in addition to

reflecting on the way they had worked, problems in the pathway and areas of improvement were identified.

A team action plan was also devised as a result of the process mapping exercise, with several areas for improvement, such as a review of the team's assessment criteria for admission and improving communication with other agencies, e.g. the National Offender Management service and supported accommodation. On a positive note, the team also reflected that they had accepted a number of service users who had spent long periods of time in services and, in the past, were likely to have been in out of area placements. Members of the team have made comments including:

"I think it provides a structured treatment plan with clear milestones that can be referred back to, ensuring treatment aims have been met/reviewed."

"I have felt the process mapping has really helped to provide a clearer insight to service users with what they need to do within their care pathway. It has also helped to define the different processes within each strand, which has also been helpful for myself."

"Essential for improvement of novel services. Aided reflective discussion and action plans."

The second exercise of designing posters through consultation meetings with service users, which show a less complex flow chart of the care pathway, is still ongoing. The meetings with the service users have generated discussion through: them being able to identify visually from the poster, where they are in the care pathway, and what work they still have to do. Service users were able to reflect on where they felt they were in relation to the pathway and

also contribute to the design of posters. They have made recommendations, such as adding approximate timescales for work and using a traffic light system for the stages of the process. Service users have made comments including:

“This should have been done from the start”

“I think this will make things easier” (service user referring to a format for an action plan from Care Programme Approach reviews)

“I haven’t done that part” (service user referring to the ‘relapse prevention’ part of a poster)

Process maps can be complex, time-consuming, and rely on a commitment from

those involved to meet frequently. It would have been positive to involve service users in the initial stage; however, it quickly became apparent that these sessions were useful in terms of reflecting on the care of individual service users.

The aim is that the posters will support staff and service users to visualise the care pathway together. It has also encouraged greater reflection and a cohesive, structured approach within the multi-disciplinary team. As detailed above, work in relation to service user posters is still ongoing and the next stages include seeking approval through the clinical governance procedures and educating staff in using the process maps during their discussions with service users.

Elaine Hoffman, Advance Nurse Practitioner for Personality Disorders, The Tamarind Centre

South West Yorkshire Partnership NHS Foundation Trust

Increasing Compassion for Service Users Diagnosed with a Personality Disorder Through Team Formulation in a Low Secure Forensic Unit

What is team formulation?

“Team Formulation (TF) refers to the process of facilitating a group or team of professionals to construct a shared understanding of a service user’s (SU) difficulties. It provides a structured way to integrate information from members of a multi-disciplinary team (MDT) and generate hypotheses to inform intervention planning” (Cole, Wood, & Spendelow, 2017, p. 15).

How team formulation can help service users diagnosed with a Personality

Disorder (PD)

The National Institute for Health and Care Excellence (NICE) advises a collaborative approach to SUs diagnosed with Borderline Personality Disorder (BPD), particularly regarding risk (NICE 2009b). This collaborative approach can therefore be developed through TF.

Background

The Bretton Centre is a low secure male forensic unit within the South West Yorkshire Partnership NHS Foundation Trust. The current TF project stems from the New Ways of Working agenda, involving psychologists shifting from direct therapy work to being part of a MDT, with an increase in the ‘beyond therapy’ roles such as consultation, supervision and training (Onyett, 2007). Within this changing landscape, there has been a rise in the use of formulation with staff teams, with an emphasis on increasing the psychological mindedness of MDTs (DCP, 2011).

Studies conducted to date have suggested many potential benefits of TF. Lake (2008) highlights how detailing a developmental history in a TF, which links the client's way of coping with distress as a child to how they are behaving in adulthood, increases staff empathy, reporting that staff can find it "easier to have more compassion" (p.19). Within the criminal justice system, staff exposed to TF have reported: increased awareness and understanding of their clients' difficulties, such as those associated with 'PD'; increased use of a person-centred approach, e.g. empathic listening; development of formulation skills; and defensible practice through having a more holistic view of the person following TF (McMullan, Ramsden & Lowton, 2014).

Berry et al. (2017) researched the impact of TF on patients. The increased levels of staff empathy correlated with SUs being "more comfortable approaching staff" (p.1219), and staff were reported to be more "encouraging and less critical" (p.1218). TF can therefore be a valuable tool in creating a compassionate and therapeutic environment in low secure units.

Our Research

In the current study, MDT staff came together fortnightly for TF. The structure followed a schema-informed model. The model covered the questions: what do we know? What does this tell us? What can we do for the SU? This diagram was projected onto a screen and results from the discussion were typed live during the meetings (Diagram based on the TF template from the Yorkshire and Humberside Offender Personality Disorder Partnership).

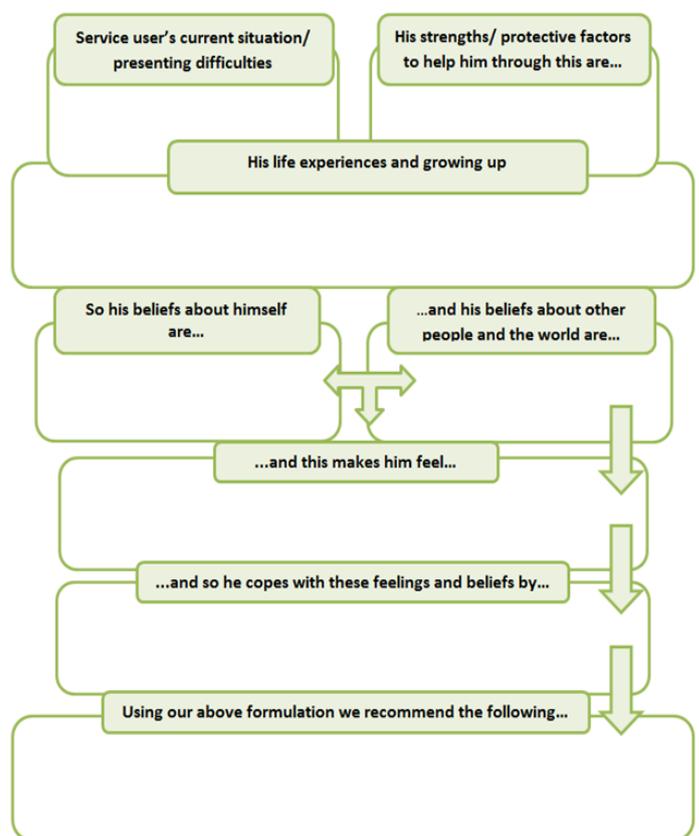
Prior to taking part, staff were given the "Balanced Index of Psychological Mindedness" (BIPM) (Nyklíček, I & Denollet, J. 2009) questionnaire and a "working in teams" questionnaire, which was then repeated after 6 months of TFs. After each meeting, a session feedback form was given to staff.

Our Findings

The average score for the BIPM and the "working in teams" questionnaire increased at the 6-month review. This correlates with increased:

- Cognitive and affective empathy (Beital et al., 2005)
- Awareness of self and others (Beital et al., 2005)
- Emotional intelligence (Giromini et al., 2015).

Themes for the most useful learning aspects of TF emerged from the session feedback forms. Discussion of the SU's full 'background history' was a prominent theme. This allowed staff to develop greater compassion and understanding towards SUs. The 'group discussion' format of TF was positively reviewed as staff appreciated "gaining a wider perspective from other professionals", as this led to recommendations which "guided care planning", for successfully thought out treatment pathways.



TF allowed staff's 'Engagement with SUs' to improve. Staff reported that understanding the SU's thoughts and feelings helped them to "form a therapeutic relationship", and to "ensure a consistent approach from all staff". Staff engagement with SUs was also suggested to be more psychologically informed after TF. Some stated that they will now "think more in terms of *why* SUs are behaving that way", others said that they would "keep the TF framework in mind" when interacting with SUs.

The literature has shown how TF can increase understanding of difficult behaviours, which is often the key area which staff struggle to understand, when working with SUs with a diagnosis of PD. By introducing this forum into our low secure service, greater compassion has been instilled, which may indirectly improve outcomes for our SUs.

Bethany Temple, Year in Industry Placement Student and Elaine McMullan, Clinical Psychologist, Bretton Centre

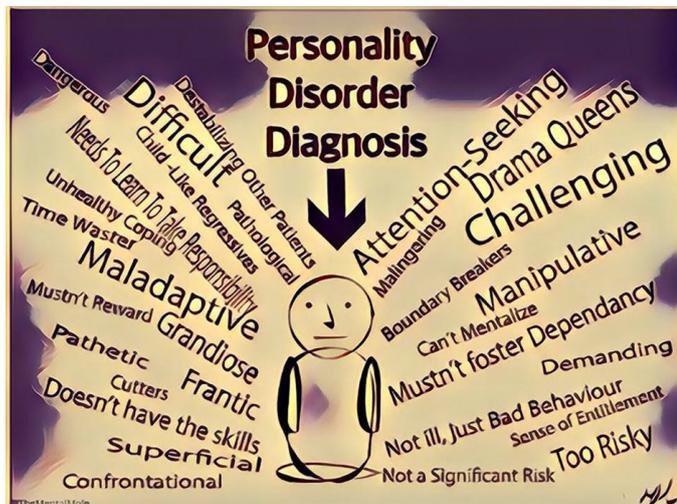
Independent Research Collective

'Leaving Personality Out of It': Reframing Forensic Mental Health Treatment Pathways for Traumatized People

"Dear MH Worker: We don't feel the need to comment on your personality, what gives you the right to comment on ours? We come to you for help and support, not a medically sanctioned character assassination." (Survivors against PD @SurvivorsNotPD, Twitter, 8 February 2018)

We propose that the notion of an effective treatment pathway for the contested attribution 'personality disorder' is now a contradiction in terms because 'personality disorder' is in itself a term that lacks validity and needs to be abandoned. Let's leave 'personality' out of it altogether.

The contested term 'personality disorder' is the direct descendant of the attribution of 'moral insanity' and is critiqued by a vast literature. NIMHE (2003) sought to end the use of the term as a pretext for exclusion from treatment (or for mistreatment). To read the following passage from this report, fifteen years on, is immediately to see how little has changed:



"40. No mental disorder carries a greater stigma than the diagnosis "Personality Disorder", ... professionals ... often equated it with untreatability.

41. Many [survivors] reported being called time-wasters, difficult, manipulative, bed-wasters or attention-seeking. ... They felt blamed for their condition and often sought basic acceptance and someone to listen to them ... rather than being told "you're not mentally ill".

42. 'Antisocial personality disorder' was felt to be even more stigmatising ..." (p. 20)

Image © Robyn Timoclea 2018. All rights reserved.

Gary H (2018) has written powerfully of the ways in which an identity around the contested diagnosis was forced upon him by the system of care:

"I was called a manipulative attention seeker. People only wanted to talk about what they saw as my negative traits. I was often referred to, not by my name, but as a Borderline I accepted my diagnosis of Borderline Personality Disorder without question. Everything was my fault. I felt hopeless. I knew I deserved to be treated badly by professionals. I expected it." (2018 p.7)

Survivors tagged with this pejorative label should lead the reframing process. The UN Convention on the Rights of Persons with Disabilities (CRPD) uses the term 'psychosocial disability', broadly defined so as to include the contested domain of 'personality disorder'. Clause (o) of the 'Preamble' proclaims:

"(o) persons with disabilities should have the opportunity to be *actively involved in decision-making processes about policies and programmes*, including those directly concerning them,"

The Report of the UN Special Rapporteur (2017) observes (p. 6):

"21. *The promotion and protection of human rights in mental health is reliant upon a redistribution of power in the clinical, research and public policy settings.*"

And recommends (p. 20) that:

"92. (b) *States and other relevant stakeholders ... recalibrate mental health research priorities to promote independent, qualitative and participatory social science research, exploring alternative service models that are non-coercive*"

The 'Consensus Statement for People with Complex Mental Health Difficulties who are

diagnosed with a Personality Disorder', launched in January 2018, unequivocally calls for the abandonment of the diagnostic frame.

"We believe that helping people with these type of problems needs some new thinking from the system: about the importance of relationships and our early lives, about the skill mix of staff, about involving people in their care" (p. 14)

The day after this was published, a group of researchers published the *Power Threat Meaning Framework* (PTMF), intended as an alternative frame to medical diagnosis for contextualising all human distress and troubled/troubling behaviour:

"This framework replaces the question 'What is wrong with you?' with four others:

- 'What has happened to you?' (How has Power operated in your life?)
- 'How did it affect you?' (What kind of Threats does this pose?)
- 'What sense did you make of it?' (What is the Meaning of these situations and experiences to you?)
- 'What did you have to do to survive?' (What kinds of Threat Response are you using?)"

(PTMF, p. 9)

The diagnostic frame of 'personality disorder' is increasingly the love/hate that dare not speak its name. It's time now for the system of care to abandon, to the incoming tide of critique and alternative trauma-informed models, that bleak and dispiriting and increasingly indefensible conceptual terrain.

Robyn Timoclea and Kati Turner; Survivor Researchers and Activists; John Adlam, Consultant Adult Forensic Psychotherapist, Bethlem Royal Hospital and an independent researcher (views expressed here are his own).

Her Majesty's Prison Service

Good Practice Development Through Creative Networking. Community of Communities and Enabling Environments as Examples of Organic Service Development Models

Working in the field of personality disorder throws up many contradictions. We work with people who suffer and who may cause suffering to others. How should the balance of resources be allocated? What is the most effective way of working and how should this be managed and monitored? How can creativity and thoughtfulness be encouraged while treatment integrity be maintained? (Howells, Krishnan, & Daffern, 2007; Jones, 2010). All of these matters are contentious and open to challenge according to prevailing academic paradigm or political discourse.

For the past eighteen years, I have worked with prisoners in both health and prison settings. This is stressful work. The criminal justice system demands constant attention and reassurance because the perspective of the public is rightly concerned with safety, though sometimes less usefully preoccupied with blame and revenge.

However, it is important to remember that it was the forensic imperative that attracted both attention and funding to the field of personality disorder in the late twentieth and early twenty first centuries. The political pressure to manage, control, and eliminate serious crime fed into a frenzied debate about how this could be achieved, with preventative incarceration being a serious option. The debate moderated, and with it came the recognition that not only were many offenders seriously disturbed, but that much distress and disturbance existed within the wider, non-offending population (Department of Health, 2003). It

was through this route that services in the community began to develop and thrive. Small units, telephone communities as well as substantial hospital-based units, and hugely expensive Dangerous and Severe Personality Disorder units. Much of the thought and planning for these projects was conducted with user groups and professionals, with policy papers and training guidance being published through the National Institute for Mental Health. Meanwhile, there was a parallel field of activity which involved the 'old' personality disorder treatment services, the therapeutic communities (TCs): the Henderson and Cassel Hospitals, HMP Grendon, the Ingrebourne Centre and many more in psychiatric, prison and children's services. Since the earliest days of the Association of Therapeutic Communities (ATC), psychiatrists had played an active part in the development, support and protection of many of these communities. So it was perhaps fitting that the Royal College of Psychiatrists should facilitate the project which sought to forge an accommodation with the developing world of managerialism, audit and review (Ward, 2011). The project also had to take account of key guiding principles for service development, as described in the document 'Personality disorder: no longer a diagnosis of exclusion' (Department of Health, 2003). These include:

- Listens to feedback and has strong voice from service users
- Supportive peer networks
- Involves patients as experts
- Attitude of acceptance and sympathy
- An atmosphere of "truth and trust"

These should all be features of a good Therapeutic Community (TC) which is open to change and organic growth through active involvement of professionals and service users. It was through a collaborative partnership with the ATC that the Community of Communities (C of C) began. What is now an established element

of the College Centre for Quality Improvement (CCQI), began in the year 2000 with a series of workshops involving service users and professionals from many settings. The object of the workshops was to try to establish the common features of a good therapeutic service, and to do so in a way that could provide a means for peer review and support within a network of facilities, which had a core basic understanding of each other ('CofC Community of Communities Process Document 2015-2016.pdf', n.d.). So, I could visit a prison, or a mental health hostel, or a medium secure unit, and recognise a place where communication was open, reflection was encouraged, it felt safe, and change and development was supported.

Although almost a hundred projects participated in this C of C network, that was not the end of it. It became clear that if you separated the activities from the standards, with some adjustment, these standards were good for any healthy setting. The Enabling

Environments (EEs) project became a quality network in its own right and aims to bridge distinctions between clinical and non-clinical settings, to develop a single common core vocabulary applicable across a range of agency and service environments ('Introducing the award', n.d.). With the TCs' review and accreditation process, the object is to support development, to help raise standards and to recognise good practice already in place.

Together, TCs and EEs have supported several hundred projects. Many, such as approved premises, have received affirmation of excellent work and clarity about areas for improvement that were previously obscure and the process of preparation (while time consuming) has by itself been inspirational.

David Jones, Psychoanalytic Psychotherapist, Millfield Medium Secure Unit, HMP Grendon and HMP Gartree

Cygnets Healthcare

Promoting Collaboration in HCR20³ Risk Assessments: An Audit of Service User and Multidisciplinary Involvement in a Low Secure Setting

The HCR-20 is the one of the best validated and most widely used violence risk assessment tools (Singh et al, 2014). It is recommended as a best-practice risk assessment tool by the Department of Health (2009).

Cygnets Hospital Bierley completes HCR20³ risk assessments within three months of service users coming to our female low-secure ward and male low-secure ward.

Assessments are reviewed at least every six months, in line with the CPA cycle.

A review of the hospital's HCR20³ process in 2014 revealed that assessments were usually conducted by one professional as opposed to a multidisciplinary team (MDT) and service user involvement was inconsistent. In addition, there was no explicit process for sharing the assessment outcomes with stakeholders or using outcomes to inform the care and management of service users. Thus, our HCR20³ assessments were not being used to the maximum clinical benefit of the service user.

This presented an opportunity to develop an approach in which HCR20³s were used in a meaningful way so that teams and service

users gained a greater understanding of risk and factors that help to reduce and/or manage it.

Our new process

In 2015 the Psychology department established a new HCR20³ process (Figure 1), with the following aims:

- To involve the service user in his or her HCR20³ risk assessments and the development of their risk management plan
- To involve a minimum of three multidisciplinary team members in each assessment and management plan
- To provide a psychological formulation of risk which informs collaborative care planning with the service user and MDT.

Collaboration with Service Users

A key aim is to promote service user involvement in the completion of his or her risk assessments, management plans and 'Helpful Tips' sheet (a short summary of the risk formulation and management strategies, to be shared with the service user and care team). Research suggests that collaborative risk assessments enable service users to become aware of their own risk, take responsibility and feel empowered to prevent future violent behaviour (Horstead & Cree, 2013). Collaboration may also enhance therapeutic relationships with staff, which in turn can increase a service user's motivation to embrace change (Horstead & Cree, 2013).

At Cygnet Hospital Bierley, we aim to give all service users an opportunity to discuss their self-perceived risks and explore factors that decrease and increase these. This interview is carried out by a clinical or forensic psychologist, an appropriately trained and supervised assistant, or trainee psychologist.

Assessor to:

1. Complete assessment and coding of historical factors
2. Complete assessment and coding of clinical factors
3. Develop a risk formulation (to be shared and revised later with team and service user).

Assessment to be informed by: BPS guidance on psychologically informed risk management; clinical records; reports from previous services; relevant records from the criminal justice system wherever appropriate and possible (e.g. PNC records, MAPPA minutes, risk management assessment or plans from probation) liaison with multidisciplinary team; interview with patient (where possible).



- ✓ Assessor to interview service user
- ✓ Assessor to meet with at least 3 disciplines from the patient's care team (including the named nurse wherever possible).
- ✓ Outcomes of assessment and management plan to be shared / discussed with the service user on a 1:1 basis.
- ✓ Outcomes of assessment and management plan



Assessor to finalise report, incorporating feedback from the care team and service user.



Creation of an individualised 'Helpful tips sheet' for relational security, informed by the risk formulation and feedback from the service user and care team. To be shared with service user and care team.

Collaboration with the multidisciplinary team

MDT collaboration is a principal of best practice for effective risk assessment and management (Department of Health, 2009). Multidisciplinary working improves both the comprehensiveness of information considered and the implementation of management plans (Beazley, Carter, Stewart, & Renton, 2017). We aim to involve a minimum of three disciplines

(including psychology) in the completion of each HCR20³ risk assessment.

How successful have we been?

Fifty HCR20³ risk assessments were completed at Cygnet Hospital Bierley during 2016. Two thirds involved the collaborative participation of the service user, as shown in *Figure 2*.

Service User involvement in HCR20 assessments (n = 50)

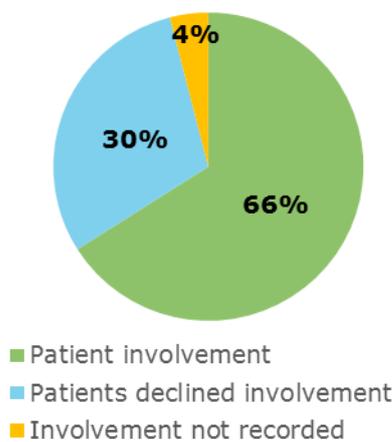


Figure 2. Service User Involvement in HCR20 Assessments

A third of assessments did not involve the service user, this was primarily due to individuals declining involvement, which has been identified as a significant barrier to collaboration (Tambuyzer, Pieters, & Van Audenhove, 2014). The frequency of each discipline’s involvement is shown in *Figure 4*.

In summary, implementation of a new HCR20³ process has resulted in high levels

Distribution of discipline involvement with HCR20 reports (n=50)

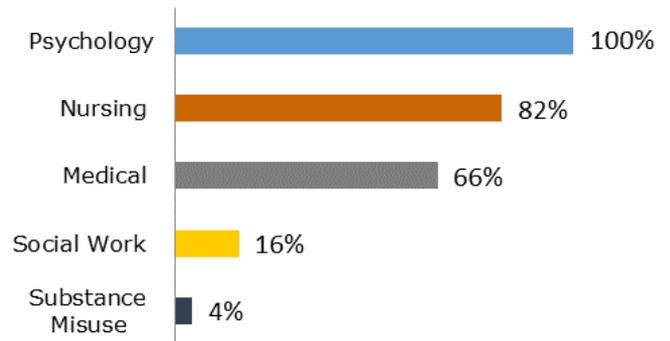


Figure 4. Distribution of Discipline Involvement with HCR20 Reports

of multidisciplinary and service user involvement. This has enabled us to complete comprehensive and collaborative assessments of risk of violence, which can be used to inform relational security and the care of service users.

Current Research

We are interested to know if our service users perceive their HCR20³ involvement as meaningful and truly collaborative. To throw light on this matter, we are carrying out a qualitative exploration of service users’ experience of participating in their HCR20³ risk assessments. We hope to use the findings to inform improvements to our practice and further increase the extent and quality of meaningful service user involvement.

Fleur Currie, MSc Forensic Psychology Student and Sophie Walsh-Harrington, Assistant Psychologist, Cygnet Hospital Bierley

Visit the Quality Network for Forensic Mental Health Services (QNFMHS) website

www.qnfmhs.co.uk

Treatment on Cannock Ward in the Personality Disorder Service at Arnold Lodge: The Patient's Perspective

The Personality Disorder service at Arnold Lodge Medium Secure Unit (MSU) in Leicester comprises two 12-bedded wards. Patients are usually initially admitted to Ridgeway ward and when behaviourally settled and able to engage in more intensive psychological treatment, are then transferred to Cannock ward. The information below has been written by several of the patients on Cannock ward.

There are many aspects to the treatment programme on the ward. Much of the treatment is delivered in groups, including groups to improve skills, such as problem solving, social skills, anger management, and emotional regulation. Then, there are groups to address specific treatment needs, such as groups to address substance misuse, criminal thinking, or fire-setting. We also have individual sessions with nursing staff and other members of the multidisciplinary team - one to ones. This gives us the chance to explore any issues and problems that we experience. It also helps us learn to trust staff, which many of us find difficult.

Problem solving is one of the first groups that we are expected to attend. This group helps us recognise when we experience a problem; clearly identify the problem; decide what we want to achieve and then consider the most appropriate way to do this. This method is repeated over and over again so that we become more effective at managing problems. This skill is used in many of the other treatment groups to help us make better decisions, plan for the future and reduce the likelihood of

offending.

An important part of the treatment programme is attending community meetings twice daily, where we are expected to bring up problems that affect us and challenge our peers' negative behaviour. This is a safe place to practice the skills we are learning and learn to resolve conflict effectively.

There are opportunities to learn new skills and interests including education, attending various committees, vocational groups (such as gym, art and cookery) and work skills placements. These help build our skills, confidence, self-esteem, and interpersonal skills. It also helps to prepare us for working in the community.

An important skill that we are expected to learn is how to manage our own time effectively. To help with this, we have certain periods of times where we are expected to identify and complete work independently. This is called self-directed study, which many of us find quite difficult. It also offers an opportunity to learn to manage boredom.

The programme on Cannock ward is very structured. We have to get up and negotiate at 8.00am. This is the time when we plan our day, which many of us have not done previously and it helps provide more structure to our lives.

As we progress in our treatment, we start preparing to move on. The Transitions group helps us explore potential problems we may face and manage these. Community leave is another opportunity to help prepare for discharge, initially being escorted by a member of staff and eventually unescorted. This helps us to set and achieve community-based goals, such as voluntary work or college. It also helps to practice tasks that we have previously found difficult.

Overall the treatment on Cannock ward is very beneficial and has helped us become more aware of how we affect the people around us and how we affect ourselves. Although many of us share similar problems, we all have different problems and find different parts of the treatment beneficial.

When asked which part of the treatment we found most helpful, some responses included:

"The structure is very helpful. I never had any structure in my life and initially found it too regimental. However, it helps me to get things done and gives me a sense of purpose"

"Learning that I can't have what I want immediately and having to work for goals."

"Learning to successfully resolve conflict with others in the meetings. I would have previously been aggressive or ignored the

person. However, after resolving the problem, I often find I actually get on with the person"

"Learning to socialise and to get on with others"

"Being different to prison - including feeling safer, not having our bedroom doors locked at night, and feeling able to access support from staff. Even the fact that staff don't wear uniforms makes them more approachable"

Treatment on Cannock ward is very challenging at times but also very rewarding. We learn to support each other and accept support from staff. We learn a lot about ourselves and try to plan for a more successful future.

Service Users; Penny Banarjee, Consultant Forensic Psychiatrist and Simon Gibbon, Consultant Forensic Psychiatrist, Arnold Lodge

Oxford Health NHS Foundation Trust

Pathfinder Service

Individuals with personality difficulties, who also pose a significant risk of serious harm to the public, have proven to be both, a major public health concern and public protection issue. Since 2000, UK legislation, guidance and investment has stimulated new pilot services in order to meet the needs of this risky and vulnerable population and to establish effective clinical interventions and initiatives to reduce their risk to others while improving their psychological well-being. Thankfully, there is the increasing necessity to recognise and address the high levels of personality and mental health difficulties of those with forensic needs (Joseph & Benefield, 2012), especially those being managed in the

community. In recent years, a National Personality Disorder Strategy (Joseph & Benefield, 2012) has been implemented to begin to provide access to psychological therapies and to therapeutic environments for people with these complex needs.

The Oxford Health NHS Pathfinder Service is one such psychological therapy service that has been developed to meet the demands for the provision of psychological treatment for individuals with complex needs, and to respond to the need for enhancing the skills and capabilities of clinicians working therapeutically with this patient group. The Pathfinder Service was developed in 2014 and aims to provide a needs-led psychological assessment and treatment service for a complex population of individuals, who typically fall outside of available community psychological and

mental health resources. We offer individual and group-based psychological therapy delivered through an integrative psychological model, underpinned by attachment and CBT principles, and the NICE Guidelines. While there is growing recognition of the potential for community based psychologically led programmes, research is limited as to the effectiveness of treatment, as well as in understanding which factors may influence better treatment outcomes. The Pathfinder Service is currently evaluating the effectiveness of its treatment and is contributing to the development of a national service-wide evaluation of treatment delivery.

The Pathfinder Service receives approximately 90 referrals per year, offering our assessment and treatment service to approximately 2/3 of these referrals. As is commonly experienced, engagement and motivation strategies form an essential part of early interventions, especially in how we engage and 'hold' patients referred to us for treatment as a result of dysregulated behaviour and chaotic lifestyles, which mean that they are often difficult to engage in traditional psychological services.

Similarly, patients that are referred to the Pathfinder Service are often considered too complex and dangerous to be seen by psychological/talking therapies services and the nature of offenses can greatly disturb any group programme not specifically designed to meet their needs. As such, we believe that creating a consistent and responsive therapeutic space reduces feelings of alienation from healthcare services commonly experienced by patients with these difficulties (e.g. Livesley, 2003), and helps to promote a more supportive and conducive therapeutic space for understanding and managing their risks and needs.

It is understood that the therapeutic model, treatment environment and therapeutic culture is fundamentally important in

promoting engagement and participation in psychological therapies, as well as encouraging and maintaining a readiness and willingness to engage in treatment (Andrews & Bonta, 2003; Howells & Day, 2007; Ward, Day, Howells & Birgden, 2004). This is especially so with individuals with personality difficulties (Shaw, Minoudis, Craissati & Bannerman, 2011).

Similarly, a psychologically based understanding of difficult behaviours has been found to be more effective in managing complex individuals (Turley, Payne & Webster, 2013). Developing positive attitudes toward people with personality difficulties, improving the psychological understanding of people with personality disorder and enhancing self-management skills to cope better with the challenges of working with people with personality difficulties, have positively impacted on effective practice in working with these complex individuals (Bowers & Allan, 2006).

The core principles can also be applied to individuals without such a diagnosis that also present with complex and challenging behaviours. In light of this, the Pathfinder Service also offers a consultation process to community and in-patient health services working with forensic patients that struggle with interpersonal difficulties. A consultation with the Pathfinder Team can be requested if clinical teams are working with a patient with forensic needs, where they are finding it difficult to manage their care and treatment. The consultation process aims to collaboratively think through the risk and clinical needs of the patient to begin to develop a shared formulation and potential treatment recommendations that might arise from this. This is also with the view of helping to reflect on the forensic and interpersonal needs and risks and how these might be managed.

John Cordwell, Clinical Lead for the Pathfinder Service

A System Approach to Helping People with Primary Difficulties Conceptualised as Personality Disorder

Approximately 50% of people in medium security have a diagnosis of personality disorder (PD), and for 15% of these people, PD is their primary diagnosis (NHS Benchmarking, 2016). It is common on the acute wards of our local medium secure unit for people to be admitted to hospital from prison with co-morbid PD and psychosis. Staff are often tasked with assessing the psychosis and offering treatment for this, with a plan of then returning the person to prison to continue their sentence. As part of this process, we often identify treatment needs related to a person's personality traits that would benefit from treatment. Sometimes we offer such treatment in the hospital, but this may lead to people being restricted for longer than if they returned to prison.

In addition, a prolonged hospital stay may lead them to identify themselves as a mental health service user and they may subsequently experience additional stigma. Moreover, there is a financial implication given the bed day cost of a medium secure bed compared to a prison. Alternatively, there are several people who have been transferred to hospital from prison who we transfer back to prison despite the identification of treatment needs related to their personality traits.

Up until 2011, there was little on offer in prison to meet the needs of such people beyond specific offence focused programmes, which had not been specifically designed to meet the needs of individuals with a PD. In 'Response to the Offender Personality Disorder Consultation' (2011),

there was a shift away from investing in the Dangerous and Severe PD Programme. Instead, investment was directed into probation, prison, and a few secure hospitals to support all people with a suspected PD who were considered a high risk of harm to others and involved in the criminal justice system. Due to the Offender Personality Disorder (OPD) Pathway Project, if a person who is transferred to hospital is considered to have primary needs in the domain of PD (before or after the treatment of psychosis), we now have several treatment pathways to recommend within the prison estate. However, the ability to access these pathways is dependent on the length of time remaining on an individual's prison sentence.

We recently assessed and treated a service user who responded well to antipsychotic medication but still had several personality traits that caused him/her difficulties; impulsivity, emotion dysregulation and violence supporting attitudes. With the service user's consent, we contacted the local OPD Psychologist to inform them that we were planning on returning the service user to prison and were recommending a period of treatment in a prison PD treatment service. The OPD service in our local area is part of the Pathfinder Service, a NHS England commissioned specialist service for Forensic PD, which we have existing strong links with. The OPD Psychologist met with the Offender Manager and was able to share information from the service user's admission and support them to develop a sentence plan that included treatment in a Prison PD Treatment Service. At the time of writing, the service user has just moved into this service.

Another person referred to us with suspected psychotic experiences was assessed and considered to have primarily PD needs. We were able to link with the local OPD Psychologist to support this individual being referred to a Preparation Psychologically Informed Prison Environment (PIPE) upon return to custody. We hope it will prepare

him to engage in a Democratic Therapeutic Community, which is the recommended next stage in his treatment pathway. Finally, we have also linked with the local Mentalisation Based Treatment (MBT) team, who offer a group-based intervention as part of the OPD service within probation. They will consider MBT as a treatment option for a man we returned to prison, who will soon reach the end of his sentence and has outstanding personality trait treatment needs.

This recent clinical experience demonstrates the real benefit of working across multiple agencies to support people with PD in forensic services. Maintaining close working

relationships with my colleagues in the OPD Pathway Project was vital. As a psychologist working in a medium secure hospital, I now have many more options to support a person accessing treatment for difficult personality traits beyond hospital. The OPD service benefits from the assessment information we can share, and the person receiving help is more likely to access a treatment that improves their psychological wellbeing and reduces the risk of harming someone in the future.

Andrew Newman, Principal Clinical Psychologist, Fromside & Wickham Unit

Upcoming Events

Reviewer Training

Reviewer training is a free event for staff from member services of the Quality Network. The training is a great learning experience for those who are interested in participating in external peer-reviews at medium and low secure forensic mental health services.

30 April 2018: The Royal College of Psychiatrists, 21 Prescot Street, E1 8BB

15 August 2018: Principle Met Hotel, Kings Street, Leeds, West Yorkshire, LS1 2HQ

Medium and Low Secure Annual Forums 2018

In May and June, the Quality Network for Forensic Mental Health Services is hosting annual forums for medium and low secure units. This will be an interactive event packed with presentations and workshops. It is an opportunity for professionals from all disciplines, patients and family and friends to meet and discuss key service development issues relevant to inpatient forensic mental health services in greater detail and share ideas about the future.

Medium Secure Annual Forum, 22 May 2018

Low Secure Annual Forum, 12 June 2018

Both Medium and Low Secure Annual Forums will be taking place at The Royal College of Psychiatrists, 21 Prescot Street, E1 8BB

Save the Date: Prison Transfer and Remission: Improving Practice, 27 November 2018

This will be a joint learning event for the Forensic and Prison Quality Network projects.

For further information on event locations and booking enquiries, please visit gnfmhs.co.uk or email forensics@rcpsych.ac.uk

Useful Links

Care Quality Commission

www.cqc.org.uk

Centre for Mental Health

www.centreformentalhealth.org.uk

Department of Health

www.doh.gov.uk

Health and Social Care Advisory Service

www.hascas.org.uk

Institute of Psychiatry

www.iop.kcl.ac.uk

Ministry of Justice

www.gov.uk/government/organisations/ministry-of-justice

National Forensic Mental Health R&D Programme

www.nfmhp.org.uk

National Institute for Health and Care Excellence

www.nice.org.uk

NHS England

www.england.nhs.uk

Offender Health Research Network

www.ohrn.nhs.uk

Revolving Doors

www.revolving-doors.org.uk

Royal College of Psychiatrists' College Centre for Quality Improvement

www.rcpsych.ac.uk/quality.aspx

Royal College of Psychiatrists' Training

www.rcpsych.ac.uk/traininpsychiatry.aspx

See Think Act (2nd Edition)

www.rcpsych.ac.uk/sta

Contact the Network

Megan Georgiou, Programme Manager

Megan.Georgiou@rcpsych.ac.uk
020 3701 2701

Matt Oultram, Deputy Programme Manager

Matthew.Oultram@rcpsych.ac.uk
020 3701 2736

Jemini Jethwa, Project Worker

Jemini.Jethwa@rcpsych.ac.uk
020 3701 2671

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Email Discussion Group

msu@rcpsych.ac.uk
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Royal College of Psychiatrists' Centre for Quality for Improvement

21 Prescot Street, London, E1 8BB

www.qnfms.co.uk