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Specialist personality disorder services in England: a case for managed clinical networks?

Following the publication by the National Institute for Mental Health in England (NIMHE) of *Personality Disorder: No Longer A Diagnosis of Exclusion* (National Institute for Mental Health in England, 2003), it is perhaps surprising that so soon after there have been threats to the survival of some of the small number of existing specialist personality disorder services to which it refers. Indeed, one of the few in-patient units specialising in such disorders (Webb House in Crewe) closed in July 2004. Such closures or threats argue for closer collaboration in planning between the relevant secondary and tertiary services and also between the Department of Health, the NIMHE and local National Health Service commissioners. Not safeguarding existing tertiary specialist services, at a time of increasing awareness of the needs of patients with personality disorders, may be short-sighted.

The NIMHE guidance document argues strongly for the development of more local (secondary-level) specialist services to meet the healthcare needs of patients with personality disorders. Within general adult psychiatry, its ambition is to see the establishment of specialist multidisciplinary teams – specialist ‘hubs’ linked to ‘spokes’ within the local multi-agency services. The document also provides a blueprint for the development of relevant forensic services.

The new developments thus represent a considerable demand for training. Therefore the document identifies the training input required to deliver this overall ambitious agenda – an enterprise logically provided, at least in part, by tertiary personality disorder services. However, the document does not indicate how the existing tertiary-level services might interact with the new local personality disorder service and *vice versa*. This is a weakness requiring rectification for referring clinicians, commissioners and service users – anyone needing to navigate the system.

This paper presents a framework for how tertiary-level specialist personality disorder services might begin to connect with one another and also with secondary-level services, through the formation of ‘managed clinical networks’ (Kunkler, 2000). We suggest that there is not only a need to understand the role of tertiary services such as Webb House, but also how they interface with

secondary services. We recommend the creation of an integrated whole that can be managed to maximise the likelihood of the provision of a comprehensive service for patients with personality disorder – an aim of the NIMHE.

The place of tertiary services

Tertiary services cater for a patient population area greater than that of the local area of their hosting trust, and/or receive the majority of referrals from secondary-level rather than primary-level services. Tertiary personality disorder services are distinguished from secondary-level psychiatric services by their specialisation. They operate some form of ‘selection’ of patients, a seeming luxury unavailable to their referring colleagues. Their inclusion criteria (but, importantly, also exclusion criteria) tend to have developed through custom and practice rather than by original design, and seldom through negotiation with those who use or refer to such services. Their geographical siting often reflects the residence of a local ‘champion’ more than a consideration of patients’ needs or referrer preference. Often specialist services represent a scarce resource, as did Webb House, requiring patients to travel considerable distances to obtain the requisite treatment – although this is not always a disadvantage, for example for patients whose social networks only serve to perpetuate their difficulties.

Recognising the scarcity of their resource and attempting to respond to the ‘system’ surrounding patients, some tertiary personality disorder services have extended their assessment and treatment remit. This is to take into account the needs of carers and also aspects of the referring professional networks involved with these patients – often high users of local services. This broadens the reach of the service through its offering consultation, education, training and help with local service development. In so doing, the overall aim is to improve the fit between the needs of a patient and the combined response of the secondary and tertiary services. Ideally, professionals from the two levels work together not just during the period of tertiary specialist



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treatment but throughout the entire duration of involvement, as required. This necessitates the sharing of a much longer-term perspective of treatment and rehabilitation than has hitherto been the case.

Undergoing a specialist, tertiary-level intervention benefits some with moderate or severe personality disorder (Dolan *et al*, 1997; Chiesa & Fonagy, 2000; Bateman & Fonagy, 2001). Therefore, an issue for referrers is one of identifying patients suitable for referral – those whose condition is severe enough to warrant the intervention, but who are also sufficiently psychologically resilient and socially supported to withstand the rigours of the treatment itself. At present, the referral of patients to tertiary personality disorder specialists appears to be haphazard, governed by the personal preferences of particular clinicians as much as by the needs of their patients (Norton & Hinshelwood, 1996). Part of the reason for this is the continuing ignorance among clinicians of ‘what works for whom’ (Roth & Fonagy, 1996; Bateman & Fonagy, 2000; Warren *et al*, 2003). The situation is also complicated by the absence of agreement on what constitutes ‘severe’ personality disorder (Kernberg, 1984), although some workable definitions have been suggested (Dolan *et al*, 1995; Tyrer & Johnson, 1996).

Managed clinical networks

Managed clinical networks are linked groups of health professionals working together in a coordinated manner, unconstrained by existing organisational or professional boundaries, in the service of good healthcare provision for the patient (Holmes, 2002). The point of these networks is that they aim specifically to build on existing informal networks, formalising and refining them in the light of their subsequent evaluation. They are anything but informal networks; as the name suggests, they are ‘managed’, requiring clear areas of accountability and clearly defined boundaries. In the treatment of personality disorder there would be important interfaces between the tertiary specialist services and, for example, forensic, substance misuse and adolescent services, in addition to interfaces with the secondary-level, local ‘hub and spoke’ network.

Managed clinical networks are rare among mental health services, although there have been strong advocates of their use, including in relation to personality disorder (Holmes, 2002). Of themselves, these networks would not be a panacea for personality disorder; however, they could have a role (particularly in complex cases) where treatment involves primary, secondary and tertiary services or where multiprofessional or multi-agency services are involved, as, for example, with much antisocial personality disorder. Managed clinical networks ‘provide the opportunity for professional collaboration across existing boundaries, real or imagined’ (Holmes, 2002). The formation of intra-trust networks – the NIMHE ‘hub and spoke’ model – would facilitate the tertiary level inter-trust managed clinical network, as a logical extension.

Certain core principles of managed clinical networks have been identified (Scottish Office Department of Health, 1998):

- (a) the appointment of one person with overall responsibility for the operation of the network, be it a clinician, manager or other professional;
- (b) a clearly mapped-out structure, which sets out the points at which the service is to be delivered and the connections between the points;
- (c) a statement of expected service improvements (including an exploration of value for money) and the preparation of an annual report;
- (d) adherence to evidence-based treatment guidelines and formal agreement of all members of the network to participate in the network and practise in accordance with the evidence base;
- (e) quality assurance procedures, including audit;
- (f) patients involved in its management arrangements.

The above principles are considered in turn, to show how far there is to go in developing such a network in relation to personality disorder in England.

Overall responsibility for the operation of the network

At present there is no acknowledgement of the need to conceive of personality disorder services as a distinctive and integrated system – a ‘network’. Tertiary and secondary services exist, as if independently, to treat the disorder. Developments in secondary services may follow in the wake of the NIMHE guidance; their impact could prove to be slight, if they have inadequate links with tertiary services. Difficulty assessing severity means that some patients taken into treatment at secondary level prove too difficult to manage within that sub-system (Norton & Hinshelwood, 1996). In advance of a patient’s clinical deterioration, knowing where to refer (or whence to obtain consultation, supervision or training) are important prerequisites for embarking on long-term treatment of moderate to severe personality disorder, which is extremely prevalent in the psychiatric population (Moran *et al*, 2000; Singleton *et al*, 2000). Overall, as the ‘network’ is at such an early stage, it is premature to identify overall responsibility for it. However, the personnel of the NIMHE regional offices might be well placed to instigate and oversee such an enterprise, given their ownership of the guidance.

Clearly mapped-out structure

Managed clinical networks require clearly defined structural relationships not only between tertiary and secondary levels but within the tertiary level itself. Yet this latter structure is not evident currently, in spite of the constituent services having existed in some instances for well over half a century. In theory, there can be collaboration across existing boundaries in tertiary-level personality disorder services. Clearly, putting this into practice may not be obvious or straightforward. In spite of this, the authors and other senior clinicians from three



trusts and within three separately managed institutions (the Cassel Hospital, the Henderson Hospital and the Tavistock and Portman Clinics) have instigated an informal network to discuss matters of mutual clinical interest, in relation to patients with severe personality disorder and their management. The work is exploratory. However, there is an agreed plan to formalise relationships, through a more systematic evaluation of each other's referral processes and inclusion/exclusion criteria for acceptance into treatment, which a true managed clinical network would need. This structure might act as a point of reference, to which other structural elements, at both secondary and tertiary levels, could relate.

Statement of expected service improvements

The main aim of introducing managed clinical networks would be to make the overall service more relevant and effective. Waiting times for referral to tertiary services might be reduced and withdrawals from tertiary care might decrease, through the referrers' better understanding of the inclusion and exclusion criteria, as the 'fit' between the two improved. These and other parameters could be measured and monitored. There is already considerable evidence that tertiary personality disorder services represent value for money (Dolan *et al*, 1996; Chiesa *et al*, 2002a; Bateman & Fonagy, 2003; Davies & Campling, 2003). Changes due to the introduction of the network could thus be measured against these baselines. Parallel markers of service provision and usage would be needed for secondary services, although relevant borderline data in relation to personality disorder might not be available.

Evidence-based treatment guidelines

There is a promising evidence base, at least for some of the tertiary services mentioned by NIMHE, for example the Halliwick Day Hospital (Bateman & Fonagy, 2000, 2001, 2003) and the residential therapeutic communities: the Cassel Hospital (Rosser *et al*, 1987; Chiesa *et al*, 1996, 2002a,b; Chiesa & Fonagy, 2000), Francis Dixon Lodge (Davies & Campling, 2003) and the Henderson Hospital (Whiteley, 1970; Copas *et al*, 1984; Dolan *et al*, 1992, 1996, 1997; Menzies *et al*, 1993).

A meta-analysis of relevant randomised controlled trials of therapeutic communities has demonstrated that this treatment is effective for many individuals (Lees *et al*, 1999). A systematic review of all treatment for severe personality disorder, commissioned by the Home Office, discovered that within an overall poor evidence base, residential therapeutic communities – both within prisons and in open settings – showed the most promising outcome results (Warren *et al*, 2003). Other treatments are also advocated in the NIMHE document, although with only a weak evidence base in relation to severe disorder, i.e. patients most likely to be referred for tertiary-level treatment (Warren *et al*, 2003). Clearly these treatments have a part to play in the absence of overwhelming superiority of a single approach.

Guidelines for practice are likely to emerge with the development of new secondary-level services. They might apply, for example, to breaking the news to patients about their diagnosis, since there is evidence that this disclosure is avoided in a proportion (Snowden & Kane, 2003). Within these settings, assessments might also be standardised and treatments manualised to enable the generalisability of treatment methods. Measures of severity and symptom change might also be harmonised between units, so enabling the pooling of data that could speed up an understanding of what treatments or services work best and for whom. (The existing health economic data cited above cannot be compared directly, in part because different research methods have been used – evaluation having taken place independently as well as at different time periods.)

Quality assurance procedures

Baseline and outcome data could be routinely collected (for example, in relation to service use and mortality) so as to evaluate the effectiveness of the clinical pathways taken and to highlight any changes needed. An integrated tertiary-level system could liaise more readily with the newly formed (NIMHE-inspired) secondary-level 'hubs' below and with a range of other services horizontally and vertically, especially forensic, substance misuse and child and adolescent mental health services. Over time, preferential pathways of care would be generated, based on what appears to work best for which patients. Subsequently, these could be put to the test of formal research, once the viability of these pathways had been established through repeated use.

Patients involved in management arrangements

Going beyond a token involvement of patients requires a fundamental shift in professionals' attitudes towards people with personality disorder and the provision of support so as to capitalise on their experience. Sadly, even the democratic therapeutic communities that espouse user empowerment and rely on this for the delivery of their therapeutic approach are not leading the way in involving their service users in management (Ormrod & Norton, 2003). The fact that service users have so prominent a role in treatment and enjoy a more equal partnership relationship in therapy than is usual elsewhere in the health service might lead to an extension of the role of users in management. If not occurring during treatment, this might happen following discharge or as part of consolidating gains made during treatment.

Conclusions

To achieve the setting up of managed clinical networks, the idea of such a structural arrangement would need to be accepted as desirable and feasible and there would need to be sufficient goodwill and enthusiasm for the idea within both secondary and tertiary tiers. Given this,



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the overall management of the network might reside with a body outside the clinical provider units; this body would monitor service quality and value for money. However, the close involvement of clinicians would be crucial to ensure that feasible clinical targets were set, which could be safely met within the constraints of the service.

Being 'horizontal', managed clinical networks contrast with conventional 'vertical' hierarchical management structures with which they will inevitably come into contact. Each system needs to be aware of the other and of ways of ensuring that their objectives are compatible, especially where high-risk patients are concerned. The proliferation of meetings that could be associated with the establishment of managed clinical networks, potentially taking clinicians away from direct patient care, would need to be guarded against (Holmes, 2002).

It remains to be seen to what extent the NIMHE guidance will or can be taken up by primary care and other trusts, in the absence of secure funding streams. Some are optimistic that money earmarked for personality disorder will remain in the field of mental health (Snowden & Kane, 2003). There is clearly a long way to go. However, the reconfiguration of secondary and tertiary services into managed clinical networks might represent one way of making the most of the limited new resources.

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References

- BATEMAN, A. W. & FONAGY, P. (2000) Effectiveness of psychotherapeutic treatment of personality disorder. *British Journal of Psychiatry*, **177**, 138–143.
- BATEMAN, A. & FONAGY, P. (2001) Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry*, **158**, 36–42.
- BATEMAN, A. & FONAGY, P. (2003) Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. *American Journal of Psychiatry*, **160**, 169–172.
- CHIESA, M. & FONAGY, P. (2000) Cassel Personality Disorder Study: Methodology and treatment effects. *British Journal of Psychiatry*, **176**, 485–491.
- CHIESA, M., IACOPONI, E. & MORRIS, M. (1996) Changes in health service utilization by patients with severe personality disorders before and after inpatient psychosocial treatment. *British Journal of Psychotherapy*, **12**, 501–512.
- CHIESA, M., BATEMAN, A. & WILBERG, T. (2002a) Patients' characteristics, outcome and cost—benefit of hospital-based treatment for patients with personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, **75**, 381–392.
- CHIESA, M., FONAGY, P., HOLMES, J., et al (2002b) Health service use costs by personality disorder following specialist and non-specialist treatment: a comparative study. *Journal of Personality Disorders*, **16**, 160–173.
- COPAS, J. B., O'BRIEN, M., ROBERTS, J. C., et al (1984) Treatment outcome in personality disorder; the effect of social, psychological and behavioural variables. *Personality and Individual Differences*, **5**, 565–573.
- DAVIES, S. & CAMPLING, P. (2003) Therapeutic community treatment of personality disorder: service use and mortality over 3 years' follow up. *British Journal of Psychiatry*, **182** (suppl. 44), s24–s27.
- DOLAN, B. M., EVANS, C. & WILSON, J. (1992) Therapeutic community treatment for personality disordered adults: changes in neurotic symptomatology on follow-up. *International Journal of Social Psychiatry*, **38**, 243–250.
- DOLAN, B., EVANS, C. & NORTON, K. (1995) Multiple axis-II diagnoses of personality disorder. *British Journal of Psychiatry*, **166**, 107–112.
- DOLAN, B. M., WARREN, F. M., MENZIES, D., et al (1996) Cost-offset following specialist treatment of severe personality disorders. *Psychiatric Bulletin*, **20**, 413–417.
- DOLAN, B., WARREN, F. & NORTON, K. (1997) Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *British Journal of Psychiatry*, **171**, 274–279.
- HOLMES, J. (2002) Acute wards: problems and solutions: Creating a psychotherapeutic culture in acute psychiatric wards. *Psychiatric Bulletin*, **26**, 383–385.
- KERNBERG, O. (1984) *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven: Yale University Press.
- KUNKLER, I. H. (2000) Managed clinical networks: a new paradigm for clinical medicine. *Journal of the Royal College of Physicians of London*, **34**, 230–233.
- LEES, J., MANNING, N. & RAWLINGS, B. (1999) *Therapeutic Effectiveness. A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders*. York: University of York / NHS Centre for Reviews and Dissemination.
- MENZIES, D., DOLAN, B. M. & NORTON, K. (1993) Are short term savings worth long term costs? Funding treatment for personality disorders. *Psychiatric Bulletin*, **17**, 517–519.
- MORAN, P., JENKINS, R., TYLEE, A., et al (2000) The prevalence of personality disorder among UK primary care attenders. *Acta Psychiatrica Scandinavica*, **102**, 52–57.
- NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (2003) *Personality Disorder: No Longer a Diagnosis of Exclusion*. London: Department of Health.
- NORTON, K. & HINSHELWOOD, R. D. (1996) Severe personality disorders. Treatment issues and selection for inpatient psychotherapy. *British Journal of Psychiatry*, **168**, 723–731.
- ORMROD, S. & NORTON, K. (2003) Beyond tokenism in service user involvement: lessons from a democratic therapeutic community replication project. *Therapeutic Communities*, **24**, 105–114.
- ROSSER, R. M., BIRCH, S., BOND, J., et al (1987) Five-year follow up of patients treated with inpatient psychotherapy at the Cassel hospital for nervous disease. *Journal of the Royal Society of Medicine*, **80**, 549–555.
- ROTH, A. & FONAGY, P. (1996) *What Works for Whom: A Critical Review of Psychotherapy Research*. London: Guilford.
- SCOTTISH OFFICE DEPARTMENT OF HEALTH (1998) *Acute Services Review Report*. Edinburgh: Stationery Office.
- SINGLETON, N., BUMPSTEAD, R., O'BRIEN, M., et al (2000) *Psychiatric Morbidity Among Adults Living in Private Households*. London: Office for National Statistics.
- SNOWDEN, P. & KANE, E. (2003) Personality disorder: no longer a diagnosis of exclusion. *Psychiatric Bulletin*, **27**, 401–403.
- TYRER, P. J. T. & JOHNSON, T. (1996) Establishing the severity of personality disorder. *American Journal of Psychiatry*, **153**, 1593–1597.
- WARREN, F., PREEDY-FAYERS, K., MCGAULEY, G., et al (2003) *Review of Treatments for Severe Personality Disorder*. London: Home Office Online Publication (http://www.dspdprogramme.gov.uk/media/pdfs_research_papers/Review_of_treatments.pdf).
- WHITELEY, J. S. (1970) The response of psychopaths to a therapeutic community. *British Journal of Psychiatry*, **116**, 517–529.

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