



editorial

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Personality disorder: no longer a diagnosis of exclusion

It is perhaps not unfair to suggest that many, if not most, adult mental health services have become psychosis services, dealing with those who are suffering from severe and enduring mental illness. Personality disorders are common, and are also disabling conditions. Many of those who suffer distress as a result of their conditions, or who place a burden on others, are managed by primary care. Only those who suffer the most significant distress or difficulty are referred to secondary services, but provision is patchy even for this group. Some may be admitted to an acute in-patient unit at times of crisis, but many are unable to access secondary mental health services.

Those suffering from these conditions often describe themselves as 'the patients psychiatrists dislike'. They are made to feel blamed for their condition, and are met with prejudice and an unhelpful approach from professional staff, who often wrongly equate personality disorder with violence towards others. Personality disorder has been described by sufferers as a 'very sticky label'.

Background

The guidance *Personality Disorder: No Longer a Diagnosis of Exclusion* was published by the National Institute for Mental Health for England (NIMH(E)) on 23 January 2003. The purpose of the guidance is to encourage the development of services for those with personality disorder. Although the guidance deals with forensic services, the main task was to change the situation for those in contact with general mental health services to deliver the modernisation agenda, building on standards 4 and 5 of the National Service Framework for Mental Health.

It was clear at an early stage to the expert group that developed the guidance that there should not be an additional burden on the already stretched and pressured acute adult mental health services, particularly the in-patient units.

Services for those with personality disorder

So that the work of the expert group could be better informed, a questionnaire was sent in 2002 to all Trusts providing mental health services in England. Of those that replied, only 17% of Trusts said that they provided a dedicated personality disorder service, 40% provided some level of service and 28% provided no service. This last finding really indicates that there are Trusts that do not see personality disorder as the main focus of intervention and part of their core business. These Trusts are certainly managing such individuals, for example in drug and alcohol services, and in eating disorder services.

The evidence

The expert group in developing the guidance commissioned a number of papers that can be accessed via the Policy Implementation Guidance document on the NIMH(E) website (www.nimh.org.uk; also on www.doh.gov.uk).

A paper on the epidemiology of personality disorders by Dr Paul Moran reviews the prevalence in the community, both primary care and secondary care. The burden of personality disorder is also covered in this paper, with such individuals being more likely to suffer from alcohol and drug problems and other mental health conditions such as eating disorders. The standard mortality is seven times higher and the risks of suicide and deliberate self-harm are greater. They are more likely to experience adverse life events, housing problems and long-term unemployment. In fact, because many with personality disorder are unable to access mental health services, the burden of care and support falls on social services, housing, voluntary agencies, and the probation and prison services.

Dr Anthony Bateman and Professor Peter Tyrer reviewed the available evidence on treatment and concluded that, in general, a combination of psychological treatments reinforced by drug therapy at critical times is the consensus view. They suggest that scepticism is unfounded and there is real cause for optimism that therapeutic interventions can work for personality disorder.



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They state that the key principles for effective therapy should:

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

This paper and a complementary review of effective treatment models for personality disordered offenders by two clinical psychologists Jackie Craissati and Louise Horne, and others, can be accessed from the same website.

The proposals

For general mental health services, Trusts are asked to consider the development of specialist multi-disciplinary mental health teams to target those with personality disorder who present complex problems. These services would sit within current psychotherapy or clinical psychology services. There are some Trusts (the 17% described above) that are already doing this. Those that do not may wish to consider refocusing current services. These specialist services should provide support, consultation, supervision and training for staff working within the adult mental health service, across the Trust for specialist services and to external agencies (e.g. primary care, social services and housing). Complex patients (measured by risk, psychopathology and comorbid conditions), who place a heavy burden on other services and who require enhanced care programme approach, should be taken on by this service.

In areas with high concentrations of morbidity, the development of day patient services is encouraged.

For forensic services, Trusts are asked to consider how these services can develop expertise in the identification and assessment of offenders with personality disorder in order to provide effective liaison with multi-agency public protection panels. For some services, this could involve the provision of training for a number of existing staff and/or the creation of a small multi-disciplinary team. There is also a recommendation that between four to six personality disorder centres be developed in England, within regional forensic services, to provide a dedicated infrastructure for the assessment, treatment and management of offenders with personality disorder. These services will provide medium secure beds, specialist hostel accommodation and a community team.

Those offenders who fall within the so-called dangerous and severely personality disordered service provision will not fall within the remit of the personality disorder centres. The assessment and treatment of this group will be provided by two high-security hospitals and two high-security prisons where the development of pilot services for assessment and treatment is at an advanced stage.

Implementation

It is easy to produce a glossy document, but change requires more than this. The paucity in the provision of services for this group is mirrored by the significant education and training deficits. The service proposals outlined above will not be achieved unless appropriate training opportunities are developed for staff at all levels of experience. For doctors there is a need to consider pre-qualification and pre-registration education. If the Primary Care Trusts are to give these services funding, primary care physicians need to understand the needs of this group of people better and what could be achieved. There are also training issues for psychiatry.

There will be money to pump-prime the development of new training initiatives. A training framework is currently being developed so that organisations can be invited to tender for training to offer those providing personality disorder services the necessary support to develop effective services. There will also need to be a dialogue with professional bodies, such as the Royal College of Psychiatrists, to address the educational and training gap.

There will be some funding support for Trusts to develop the specialist personality disorder services. As part of the new National Health Service 3-year funding cycle, money has been given to Primary Care Trusts to develop new local services and ensure better coordination of existing resources. Bids will be invited in due course for the development of centres of excellence in the eight regions covered by the NIMH(E) development centres. Funding has been allocated already to support the development of three personality disorder centres (offering secure beds, community team and hostel) and one specialist hostel. Work is underway with these forensic services to develop the capital project and clinical service that will result in 45 new places at medium security and an equal number of new hostel places together with outreach teams.

Conclusions

In presenting the guidance around the country there has been a lot of interest, but also some scepticism that not much will change. Many clinicians appear to accept that the services for those with personality disorder should be better and the burden should not fall on acute adult mental health services. There are opportunities for change and it should be noted that some Trusts provide a service now, within current resources, but often by default and in an uncoordinated way.

Most Trusts relate to more than one Primary Care Trust, with each having additional money to support these developments. Strategic Health Authorities will monitor how Primary Care Trusts make use of this money. At the local level, the NIMH(E) agenda will be to encourage local teams to translate the guidance into practice and support new training initiatives with help from the local Workforce Confederation.

Local services must lobby to access funding, but the guidance is not just about new resources. There must be

a consideration of current services and a re-focusing of current staff to meet this new agenda.



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Declaration of interest

P.S. was the Chair of the expert group that developed the guidance and E.K. is the Department of Health advisor on implementation of the guidance.

Reference

NATIONAL INSTITUTE FOR MENTAL HEALTH FOR ENGLAND (2003) *Personality Disorder: no Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder*, Gateway Reference 1055. London: NIMH(E).

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