



The Bradley Commission

3 Personality disorder and complex needs

Introduction

In 2009, the Bradley Report on people with mental health problems or learning disabilities in the criminal justice system was published (Department of Health, 2009). Five years on, Lord Bradley chaired an independent commission, made up of leading figures from the fields of politics, criminal justice, policing, social care and health, to review progress and consider how the report can be implemented in the very different financial and policy environment we now face (Durcan *et al.* 2014). The commission asked Centre for Mental Health to report on areas that were under-developed in the Bradley Report. The areas the Commission chose were: 1. diversion for people from Black and Minority Ethnic communities, 2. diversion for young people entering adulthood, and 3. personality disorder as part of complex needs.

This briefing paper is based on an examination of good or promising practices we observed in services for people at each stage of the criminal justice system across England. It describes the key features of those services and then distils the core components of effective support for people with personality disorder in or around the justice system. Finally, we set out some keys to effective engagement from the insights gained from the good practice sites. Much policy attention has been given to personality disorder, but this by and large has focused on the small number of people who pose a high risk of repeated violent or sexual offending. The Commission did visit some of these services, but to learn what might be taken and adapted from these programmes for the majority of offenders with personality disorder who do not pose a high risk.

What are ‘personality disorders’?

There have always been people who have been judged by others to be at odds with those around them, and perceived to be hard to get on with and aloof, cold or callous, or emotionally volatile, or very self-centered or very suspicious. We all have personalities and perhaps one way to understand ‘personality’ is as a predisposition, in many or perhaps most circumstances, to think, react, behave and relate in particular ways. This predisposition is pervasive and of longstanding duration. Likewise, a so called ‘personality disorder’ is such a predisposition or set of predispositions that deviates significantly from most other people’s personalities.

The label ‘personality disorder’ is a controversial one and its status as a series of ‘diagnoses’ equally so. Not everyone accepts their existence at all or their legitimacy as diagnoses. Stigma applies to many if not all mental health diagnoses, but particularly so to personality disorders. This stigma has arguably been present in mental health services, leading the Department of Health to publish *Personality Disorder: no longer a diagnosis of exclusion* (2002) in an attempt to counter it. Whether one accepts such diagnoses or not, there are undoubtedly people who have particular persistent personality traits that can make everyday life challenging, and who can be experienced as ‘challenging’ by others.

Personality disorders have been found to exist in about 5% of the population (Singleton *et al.*, 2001). There are 10 different personality disorders according to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM V) (2013), a widely used diagnostic manual. They share some common characteristics:

- The disorder is enduring and differs significantly from cultural expectation and will be evident in the individual’s experience of the world, their behaviours, their moods and emotions, how they are with other people and how they control their impulses.

- The patterns above are pervasive and consistent across a range of situations.
- Signs of the disorder were evident for some time, i.e. during adolescence or early adulthood.
- The disorder cannot be explained by another mental or physical health condition.

The three Ps

“We all have parts of our personalities that cause us problems in some situations...

For someone’s personality difficulties to be considered a disorder, those difficulties must be **problematic, persistent and pervasive.**”

(Department of Health, 2014a)

Each personality disorder consists of a list of potential symptoms and any person achieving a minimum number of these can have the diagnosis applied. For some personality disorders, there can be over a 100 different possible presentations and therefore some people with the same diagnosis will have very different presentations. Many people will also have more than one diagnosis of personality disorder, and people given the same diagnosis may have very different problems (Department of Health, 2014a).

There is also clear overlap between some personality disorders and some mental illnesses, as well as common co-occurrence of mental illnesses and personality disorders. And concurrent substance misuse can mask elements of both personality disorder and mental illness.

There has been a movement to reconsider how personality disorder is thought about, moving away from the current categorical or diagnostic approach, to a more dimensional approach which considers traits or symptoms along a continuum.

Dramatic reforms to how personality disorder is diagnosed were proposed for the most recent iteration of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V), the primary diagnostic manual for psychiatry. However, these proved controversial and, in the end, no changes were made, although the alternative dimensional approach that had been proposed is now presented in section 3 of the DSM. American health insurers generally do not reimburse costs for diagnoses in Section 3 as these require more research.

“Over 30 years I have met with many people given one or other label of personality disorder and what is true for all of these and anyone with a mental illness or disability is that the diagnosis is not ‘them’, they are more than a diagnosis. People I have met with some of the most severe and pervasive personality disorders have had fluctuations in this severity and at times had appeared less ‘disordered’ and dominated by such traits.”

(Researcher and former mental health practitioner)

It has long been recognised that those with personality disorder have received very limited attention from mental health services. This is despite government guidance making it clear that this group should not be excluded from mental health services and that they need services tailored to their specific needs (Department of Health, 2002).

The 2007 amendment to the Mental Health Act changed the definition of ‘mental disorder’ so that it includes a wider range of disorders, including some personality disorders that would not previously have been covered by the act (previously only psychopathic disorder was included). The amended Act also removed the former treatability clause that applied to

people suffering psychopathic disorder and required that treatment must be deemed likely to alleviate or prevent deterioration in the patient's condition.

Personality disorder among people in the criminal justice system

While the majority of people with personality disorder do not come into contact with the criminal justice system, personality disorder is very common in the prison population, at 66% (Singleton *et al.*, 1998), and limited studies of other offender populations also suggest that it is highly prevalent (e.g. around 50% in probation caseloads (Centre for Mental Health, 2012)). This makes it vital that the whole criminal justice system is able to respond to the needs of people with a personality disorder.

The greatest policy attention and investment has invariably gone to dealing with those who pose significant harm to the public. However, the vast majority of those with personality disorder in contact with the criminal justice system do not pose such harm.

The Government's Dangerous and Severe Personality Disorder (DSPD) programme catered for around 300 or so people per year, with a limited turnover, held in special units in three prisons and two high secure NHS hospitals over the last decade. The programme in its latter years cost in excess of £60 million per year and the benefits were far from clear (Rutherford, 2010).

What is certain is that the vast majority of the nearly 60,000 prisoners estimated to have significant personality disorder traits have been untouched by this programme. In more recent times, there has been significant reform and a revised strategy for those offenders who pose a high risk of harm, increasing the number of specialist prison programmes and expanding the programme into the community for those being released from prison as well as some places for people on community sentences. (For more detail, see page 9.)

Liaison and diversion

Since the publication of the Bradley Report in 2009, investment has been made in England in services seeking to divert people with mental health problems and those with learning disabilities away from the criminal justice system. The National Liaison and Diversion Pilot Programme began in April 2014 and now covers 50% of the English population. It works with youth offending teams, courts and the police, and is an all-age and multiple vulnerability programme and this includes those with personality disorder.

The challenge for these services will be in developing pathways for the people they divert including those with personality disorder, particularly in a climate where cuts have raised the entry thresholds for many community services. The addition of community link workers (CLWs) to these teams with a particular responsibility for engagement and user involvement is showing promise. The CLWs we met in London had been able to support people who have been diverted in engaging with mental health services and even more so with supporting some of the practical needs like housing and benefits that, if unresolved, could easily spiral an individual into crisis and possible further offending. The support the CLWs offer is time-limited but nevertheless appears to be vital in engaging people with the right help and in advocating on their behalf.

Another promising practice is the development of Street Triage, where mental health practitioners are available to the police, either via radio and phone or actually in joint patrols. Evidence collected for a recent government review (yet to be published) and a review of police powers under the Mental Health Act (Durcan, 2014) suggest that these practitioners can intervene early in a crisis, averting the need for sectioning or arrests. Additionally the recent review suggests people with personality disorder feature prominently among those helped.

In gathering evidence for this briefing paper, the Commission visited a variety of services, most of which had some similar characteristics. These included:

- A tendency towards co-production, and organising services around the service user's view of their needs;
- A psychological orientation, which might include formal therapy - often adapted to address complex need, psychologically informed communication with their service users, and psychological-minded awareness training for professionals and sometimes service users;
- Practical and pragmatic support and brokerage to deal with everyday problems such housing, debt, financial planning, benefits and employment.

Additionally some also provided specific social activities for individuals who were often very socially isolated.

Psychological approaches

The psychological approaches we encountered in services that are working effectively with offenders with personality disorders included:

Mentalisation-based treatment and related approaches

Mentalisation-based treatment (MBT) is an approach developed by Bateman and Fonagy (2010) for people with borderline personality disorder (BPD) which aims to help them have more control over their behaviour and emotions, improve the quality of relationships and work towards life goals. It works on the theory that individuals with BPD have significant issues with attachment and also with mentalisation, the latter being how we understand our own and others' mental states and consequently how we interpret our own and others' actions. MBT is a manualised treatment (ie. it has a set of steps to follow) that focuses on improving attachment and an individual's ability to mentalise.

It has spawned a number of offshoots and related approaches and one we encountered was **AMBIT (Adolescent Mentalisation-Based Integrative Treatment)**, which works with young people leading chaotic lives.

MBT in the context of BPD treatment has been researched and has shown that it significantly improves outcomes and compares well with other approaches (Bateman & Fonagy, 2009). It also has been demonstrated to have lasting impact after treatment (Bateman & Fonagy, 2008).

MBT draws from a variety of psychological schools, has a common sense approach, requires less training than some other psychological interventions to acquire the skills to deliver the approach and similarly less clinical supervision and therefore may be more deliverable in less specialised settings.

Structured Clinical Management

The Structured Clinical Management (SCM) approach was also developed by Bateman, Fonagy and others, and involves regular counselling sessions, practical support, advocacy and case management. Like MBT it has been shown to be effective with people diagnosed with BPD.

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) was developed from Cognitive Behavioural Therapy by Linehan in the 1980s (Dimeff & Linehan, 2001). It seeks to reduce the incidence of unwanted behaviours and improve the regulation of emotions. The development of Mindfulness, a concept taken from Buddhist meditation practice, is also a key element of DBT. DBT has also been extensively researched and has a proven efficacy.

Some examples of practice along the offender pathway

To investigate what services were doing for people with personality disorder, we held individual meetings, semi-structured interviews and made site visits across the country.

We have structured the findings and initiatives under the following ‘offender pathway’ headings:

1. community
2. early intervention
3. police and courts
4. prisons and the Personality Disorder Strategy
5. secure mental health services
6. probation and resettlement

We also looked at the specific needs of women and the families and carers of those with personality disorder in the justice system.

In addition to those services visited, evidence from other Centre for Mental Health reviews has also been used to inform the Commission’s work, including a recent reviews of Police powers under the Mental Health Act across England and Wales (Durcan, 2014), and a whole pathway review of mental health and criminal justice across England and Wales (to be published in 2015). These reviews gave us the opportunity to visit services across the two nations and meet several hundred key stakeholders and experts (including ‘experts by experience’).

1. In the community

5 Boroughs Partnership NHS Trust (5BP) is situated between Manchester and Liverpool covering a population of approximately one million people. The Personality Disorder Hub Service gives service users an opportunity to have a voice about how services are run and in training. The Hub has delivered and developed Knowledge and Understanding Framework (KUF) training (see right), in which experts by experience co-facilitate personality disorder training for professionals. It has also co-produced an e-learning training programme

Services visited

Our thanks go to the individuals and initiatives involved for their help and cooperation.

- 5 Boroughs Partnership NHS Foundation Trust
- Brighter Futures, Chepstow House
- Camden and Islington NHS Foundation Trust
- Icebreak
- MAC-UK
- Millfields, East London NHS Foundation Trust
- Milton Keynes Mental Health Treatment Requirement Pilot
- Nottinghamshire Healthcare NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- Resettle
- Somerset Partnership NHS Foundation Trust
- Sova Support Link
- St Andrew’s
- Staffordshire and West Midlands Probation Trust (now part of National Probation Services)

and a carer training package (CRISPS) that provides awareness-level training to carers of people with a personality disorder. The trust is currently in consultation to run a pilot project to deliver a more intensive training package for carers of people with personality disorder. The aim is to help them manage crisis presentations and interpersonal difficulties more effectively. The desired outcome is to reduce service utilisation, e.g. crisis presentations, and the need for care.

The trust has also implemented a structured Tier 3 (outpatient) Personality Disorder Care

Pathway within its generic mental health services. Specialist services include Dialectical Behaviour Therapy (DBT) and Mentalisation Based Therapy (MBT). 5BP is currently in discussions with commissioners to invest in these interventions to reduce the need for more expensive Tier 4 (inpatient) services.

Camden and Islington NHS Foundation Trust provides a community outpatient service for people with personality disorder who have very serious problems coping with daily living. These could be problems in managing emotions, crises and relationships to the extent that it causes severe distress to the service user or others. The service aims “to build resilience in service users to live a ‘life worth living’ and face life’s challenges in a balanced way”. The service provides specialist psychological therapies - Dialectical Behaviour Therapy (DBT) and Mentalization-Based Treatment (MBT), a combined DBT/MBT group, and an Emotion Regulation Programme. There is also a specialist community team who adopt an evidence-based structured clinical management (SCM) model.

2. Early intervention and emerging personality disorder

The liaison and diversion and street triage pilots are key examples of early intervention and have already been described (on page 3).

Somerset Partnership NHS Foundation Trust Personality Disorder Service is a specialist service for people diagnosed with personality disorder, or for young people (16+) with emerging personality disorders. The service provides high quality, safe and effective services across Somerset and includes treatment programmes and interventions (care pathways) that reduce risk and improve wellbeing.

Icebreak, Plymouth is an early intervention service for young people aged 16–25 who are experiencing significant emotional and psychological difficulties and who, in time, may go on to receive a diagnosis of personality disorder. Icebreak offers holistic, non-

Knowledge and Understanding Framework (KUF)

The KUF is a widely available programme of training that aims to improve the response service users with personality disorder receive and to increase the capabilities and skills in staff from a range of agencies in working with these service users.

The training has several different levels, ranging from a short awareness-level course for a wide range of professionals to Masters degree level courses for those working in a specialist role.

stigmatising support through a youth agency. The multidisciplinary team offers practical, emotional and psychological support in partnership with PCT seconded staff. A GP with a special interest is also part of the team. Young people can access services at The Zone (a young people’s one-stop-shop type hub in the city centre) and on an outreach basis. This includes one-to-one work and group work, including a self-harm group run with YES counselling staff and Mind self-harm practitioners.

MAC-UK’s work is described in our briefing on Young People in Transition (Centre for Mental Health, 2014). The young people MAC-UK work with are a group that have far greater likelihood of poor mental health than other young people (Coid *et al.* 2013; Khan *et al.* 2013) and though MAC-UK are not explicitly targeting their service at young people with personality disorder, they do use the Mentalisation approach and AMBIT, though in a flexible and adapted way rather than through formal therapy sessions.

MAC-UK works with young people who have been identified as engaged in offending and anti-social behaviour, the target group is 16-25 years. The young people they work with have multiple and complex needs but are not seeking help and generally avoid anything that is overtly labelled ‘mental health’. MAC-UK’s approach is called the Integrate approach.

The Integrate approach attempts to get existing mental health practitioners, youth workers and those in criminal justice to work in an integrated and psychologically informed way with an ‘at risk’ population. Young people are engaged in activities such as sport and music, that they have co-produced with the workers and some will choose not to engage any further, but many young people use the project to develop and work on life goals, such as managing their anger, seeking help about housing, and getting work.

3. Police and courts

Nottinghamshire Personality Disorder and Development Network (Nottingham Healthcare NHS Foundation Trust) is a community service for people with a personality disorder. The Trust also has one of the first wave of national liaison and diversion pilots. The service does not formally assess people for personality disorder; rather it provides services that focus on what are known as the Three Ps: *Problematic* behaviour that is *persistent* and *pervasive*. People who are referred are likely to have had lifelong emotional, relationship and attachment difficulties, which began in childhood and often have a significant impact on them and those around them.

The service places an emphasis on individuals taking personal responsibility for their lives. In keeping with this model, along with a strong user involvement ethos, the service encourages people to opt into the group treatment programmes following referral. These programmes run to firm boundaries which users agree to at the opt-in stage. The service offers a variety of programmes dependent on the person’s needs and individuals can take different routes through the programme.

The mental health treatment requirement (MHTR) is the least used, by a significant margin, of the three community treatment requirements available to sentencers as part of a community order. In **Milton Keynes**, probation, the court, Public Health England and NHS England joined together to provide a pilot intervention programme. This **Mental**

Health Treatment Requirement pilot involved P3 (a voluntary sector provider) link workers based in the court and psychology assistants and a supervising consultant psychologist from St Andrew’s Healthcare. The programme offered psycho-social support with P3 initially engaging the clients in court and providing practical support thereafter and the psychology assistants providing adapted psychological interventions (largely Cognitive Behavioural Therapy based).

The pilot had supported over 40 MHTRs in its first six months, more than double those issued in the whole of the Thames Valley area in the previous year. Both sentencers and service users we met were very satisfied with the service.

4. Prisons

The **national personality disorder strategy programme**, which followed the DSPD programme, has set about trying to develop a pathway for a much larger group of prisoners who pose high risk of harm, and also has programmes to support re-entry to the community. The Offender Personality Disorder Strategy (Department of Health & Ministry of Justice, 2012) set out to provide a multi-pronged approach. It includes pathway development for men, women, young people and people who come from different cultural and ethnic communities.

Those accepted into the programme have a personality disorder which is linked to their offending, and pose an ongoing high risk of violent or sexual offending (the women’s pathway accepts a broader range of offending). The strategy aims to identify people early and include psychological formulation and case management from the earliest possible point as part of their sentence planning. Whilst in prison, those meeting the criteria would have access to treatment programmes, ideally in settings that support the individual 24/7.

One type of such setting is the psychologically informed physical environment (PIPE). A PIPE is a very specific unit where all of the staff have been trained in providing a psychologically-

informed approach and where specific treatment packages will be delivered. Building and maintaining relationships between staff and people in a programme are seen as key, as is at least an element of co-production in the running of a PIPE (Turley *et al.* 2013).

Another type of environment is the enabling environment (EE). An EE is a much less prescribed environment than a PIPE, but rather is a setting that attempts to deliver a set of standards developed by the Royal College of Psychiatry (2013). EEs are not specifically designed for people with personality disorder or for criminal justice settings, but have a much wider application.

EEs aim to achieve 10 standards:

1. The nature and quality of relationships are of primary importance.
2. There are expectations of behaviour and processes to maintain and review them.
3. It is recognised that people communicate in different ways.
4. There are opportunities to be spontaneous and try new things.
5. Everyone shares responsibility for the environment.
6. Support is available for everyone.
7. Engagement and purposeful activity are actively encouraged.
8. Power and authority are open to discussion.
9. Leadership takes responsibility for the environment being enabling.
10. External relationships are sought and valued.

A proposed EE visited on behalf of the Commission was a women's prison and it had planned that some women would come into it from a PIPE or more intensive environment. Thus it was seen as a next stage or progression.

Prison therapeutic communities, such as those provided at Dovegate, Gartree and Grendon are another type of environment. Prisoners opt to join these communities that offer a (limited) level of democracy or empowerment and that provide intensive treatment, largely at the group level.

The strategy sees treatment as being available at all parts of the pathway and thereby continuing in the community, along with case management, plus practical and social support.

The number of people who benefit from the programme, however, are a very small proportion of those diagnosed with personality disorder as most people with it who are in contact with the justice system do not pose a high risk of harm.

The approach the programme takes to supporting people would likely benefit other people with personality disorder. The issue is how such approaches could be scaled up to serve this much larger population. This has become all the more challenging since the recent and significant cuts to public services and particularly in criminal justice (see page 4, Prison Reform Trust, 2014). Evidence collected for the recent mental health and criminal justice review suggests that there are fewer prison officers available on prison wings, thus impeding the ability to provide a psychologically-informed approach.

The programme has developed particular pathways for women offenders and is also developing them for young people with emerging personality disorder.

A key characteristic of the Personality Disorder Strategy is workforce development and the need to train all workers from all agencies in contact with people with personality disorder in understanding the disorder and in how to work in a psychologically-informed way. This includes prison officers and probation staff and not just mental health practitioners.

Other prison-based services

In addition to national programme, we have visited other services for people with personality disorder in prisons. Parts of the service provided by **Nottinghamshire Healthcare NHS Foundation Trust** have clinical psychologists and nurses trained in psychological approaches. They offer psychological interventions, similar to those offered by community IAPT programmes, but adapted to address complex and multiple

needs and the personality disorder traits that many prisoners have. They have reported considerable success in working with clients and in improving behaviours for prisoners who had previously been regarded as discipline problems and subject to the regular withdrawal of privileges and punishment, including separation from the wider prison population.

However, the frustration for these services came on the prisoner's release. A prisoner may have served their sentence but they often continued to have therapeutic needs. However, there was usually no equivalent service in the community and most community IAPT services were unwilling to take on clients with complex needs.

5. Secure mental health services

People with personality disorder in secure hospitals are referred from a number of sources: direct from the courts or from prisons or other hospitals. Some who are admitted to hospital with a mental illness require treatment for an underlying personality disorder before being safely rehabilitated back into the community. The fundamental issue for these patients is the ability to begin to take responsibility for their personality traits that lead to high-risk behaviour. To achieve this, they require a treatment package that combines the development of insight with learning self-management skills.

People with personality disorder in hospital require different treatments and approaches to those with mental illnesses such as schizophrenia. But it is equally important to create the treatment culture of a whole ward towards a pro-social model of personality disorder treatment.

St Andrew's has developed specialist care pathways for adolescents and adult men and women, specifically tailored to the complex needs of each patient group living with a personality disorder. These programmes are designed to address personality disorders through a number of interventions, thereby providing patients with the skills to identify, understand and take responsibility for their behaviours, enabling them to progress and

become well enough to return to a community setting.

The most common primary diagnosis for patients admitted to the women's service at St Andrew's is borderline personality disorder (BPD). The women's personality disorder care pathway has a gender-sensitive, psychologically-led model of care that combines skills training and individual therapy from admission to open step down facilities. The service, which began in 1997, is based on cognitive behavioural therapy (CBT) and includes specialist dialectical behaviour therapy (DBT) at St Andrew's Spring Hill House. Favourable treatment outcomes have been published for both the medium secure CBT treatment programme (Long *et al.* 2014) and low secure DBT programme (Fox *et al.* 2014).

Spring Hill House also admits women suffering from BPD, offering low secure and open step-down environments. Appropriate referrals to Spring Hill House are for adult women and must meet the diagnostic criteria for BPD and not suffer any additional major mental illness. According to DBT principles, the service user must commit for a minimum of one year in the knowledge that the maximum stay is three years, during which she must demonstrate a continuing benefit from the programme.

Seacole at St Andrews is a medium secure facility comprising 15 beds to provide mental health treatment and recovery for women with complex needs. It provides an assessment and psychosocial treatment programmes for women with complex needs and offending histories that require detention within secure conditions.

Millfields (East London NHS Foundation Trust) is a medium secure inpatient personality disorder unit that opened on the site of the John Howard Centre (the medium secure unit for North East London, based in Hackney) in March 2006. The service is for adult men with a diagnosis of severe personality disorder who are thought to pose a significant risk to others and who require treatment within the health service. The maximum length of stay will usually be two to two-and-a-half years, and the normal pathway following treatment will be via a return to prison to complete further work.

The treatment philosophy has integrated elements from several different models, each of which has some proven efficacy. Within the framework of a therapeutic community, Millfields uses a variety of different forms of psychological therapy, from cognitive behavioural to psychodynamic, to foster the skills needed to recognise and regulate emotion, to understand the minds of others, to control impulsive or destructive behaviour, to form relationships with others that are rewarding rather than damaging, and to spend one's time enjoyably and productively.

The weekly programme provides a full, structured timetable of group and individual therapy, complemented by a balance of work, education and leisure activities. This integrated model has the added benefit of providing opportunities to tailor treatment to the very specific needs of each individual. Millfields recognises that even the most skilled staff can find this work emotionally taxing and places a special emphasis on supporting them through training, support and supervision.

In collaboration with Unity House therapeutic community and outreach service, an independent group of experts by experience and the University of East London School of Law and Social Sciences, Millfields facilities a Postgraduate Certificate in personality disorder in context: psychosocial perspectives on working with people with personality disorder. This is a Department of Health approved course which promotes effective, safe inter-agency management of complex and severe emotional, interpersonal, behavioural and social difficulties. The course places a special emphasis on developing a better understanding of the interpersonal, team and organisational dynamics that can help or hinder this work.

6. Probation and resettlement

In April 2013, the then **Staffordshire and West Midlands Probation Trust** was awarded funding from NOMS for two years to deliver a community approach to working with offenders with personality disorder in the Stoke and Staffordshire Local Development Units (LDUs)

in partnership with the two health trusts which cover the areas – South Staffordshire and Shropshire Healthcare Foundation NHS Trust and North Staffordshire Combined Healthcare NHS Trust. This is part of the national strategy for the development of work with offenders with personality disorder.

Probation officers in both LDUs are trained in the KUF (see page 7), which is the accredited approach to working with personality disorder, and work with psychologists from the two health care trusts. Their role is to support, advise and collaborate with probation colleagues across the two LDUs in managing their individual offenders, with the aims of: securing better compliance with supervision; improving access to mainstream health resources; improving risk assessment and risk management; reducing breach rates; and ultimately reducing re-offending. The psychologists principally engage in case assessment and case formulation of offenders, together with offering some supervision to staff on both a group and, occasionally, an individual basis to enable and support the development of reflective practice and to improve the skill basis and confidence of staff in dealing with this group.

Developed initially as a pilot project within the Dangerous and Severe Personality Disorder programme (DSPD), the **Liverpool Resettle** service model is consistent with recent developments to establish offender personality disorder pathways across the country. The project is an innovative community risk assessment and case management service which aims to manage and treat adult men assessed as high risk who have mental health problems that include serious problems of personality and functioning that relate to their risk.

The service is embedded within, and draws from, the wider service philosophies and drivers of mental health and probation services. Its aims relate to recovery, improving wellbeing, facilitating rehabilitation and social inclusion, harm reduction and the prevention of re-offending. Work with participants begins while they are in prison and extends to the project

in the community for up to two years; with potential for some support beyond that.

The Resettle model adopts a relationship-based approach in order to foster engagement and offer intensive support, individual case management and intervention to address both risk and need. There is a strong ethos of service user engagement and belief in the importance of continuity of relationship (including during periods of recall). Resettle is staffed by an integrated multi-agency team of health and criminal justice staff who are supported by a range of other agencies to deliver multi-modal and coherent interventions to this group of high risk offenders.

“We work very intensively, and whilst we are a non-residential service, we work closely with probation approved premises. Participants attend the project for up to six days a week and additional input can also be offered outside these times if indicated by an escalation in risk to self or others.”
(Resettle)

Resettle provides a crisis line, available out of hours, and participants are encouraged to use this if faced with a crisis. It is also available to accommodation providers and family members as appropriate. The aim of any contact is to encourage and develop confidence in self-management and problem solving skills. Furthermore, in addition to their daily attendance at the project, the participants are given the opportunity to work with volunteers who offer support to address social isolation and to promote community integration (Resettle Plus).

The Resettle Plus model is based on the Circles of Support and Accountability framework, whereby volunteers are trained to monitor behaviour which could indicate an escalation in risk while promoting social integration. On a visit to Centre for Mental Health, service users stated how much they valued the volunteers: “It’s been very important for me to be able to go visit places and even just have a coffee with XXX and XXX...otherwise when I’m not here I am on my own with my thoughts...”

Sova Support Link supports adults with lifelong psychological needs and a history of offending. It aims to improve their quality of life and enable them to live successfully as part of their local community. This is done by recruiting, training and supervising volunteer mentors, who work together in groups (known as hubs), to support an ex-offender, both practically and emotionally.

Each volunteer is asked to commit to meeting the ex-offender they’re matched with for no more than five hours per week for at least 12 months. Volunteers receive specialist training, regular support and supervision to support them in their role. As well as working with a team of fellow mentors, volunteers also work closely with other professionals involved in the ex-offender’s life. Sova Support Link covers the whole of London.

At the time of data collection for this review, **Oxfordshire Complex Need Service (CNS)** ran a range of therapeutic interventions for people with personality disorder. Some of these prepared people for more intensive therapy, sometimes in individual sessions but mainly through group work. CNS ran several low-intensity groups, medium-intensity groups and also a high intensity three-day group based on therapeutic community principles. In addition to working with people who have personality disorder, CNS also involves families and carers and provided support groups in Oxford and Banbury. These groups ran twice a month and in addition family members and carers could attend a weekend educative programme held twice a year.

Core components of effective engagement

We have identified the following as core components of effective support for people with personality disorder at all stages of the criminal justice system.

1. Assessment and sentence planning

Given the large number of both male and female prisoners (and likely offenders in other parts of the criminal justice system) that are known to suffer from personality disorder and the impact that this can have on them, it makes sense that all offenders (in any setting) be assessed for this and the results would inform their sentence plan. This would involve more robust screening and assessment for personality disorder, but also other factors that impact on relationships and behaviour, e.g. mental health, acquired brain injury, learning disability and autistic spectrum disorders.

2. Co-production of services

There is growing evidence that co-production with service users brings benefits and supports better engagement. It should be considered in all settings, even where this can prove most challenging, such as custodial settings.

Co-produced training, delivered by experts by experience with experts by occupation, clarifies misunderstandings and reduces anxiety on both sides. Co-production challenges and addresses the cognitive bias of both workers and service users. For example, service users may be biased toward an expectation of rejection and abandonment, while workers may be biased towards believing that clients with personality disorder are manipulative and attention-seeking. By understanding

what lies beneath an anger outburst, for example, which could be low self-esteem or anxiety, workers are better equipped to make the right response.

The KUF training incorporates this partnership-working model and is widely advocated.

Collaboration and partnership aid the development of psychologically-informed policies and procedures. It is also a way of educating service users around the limitations of services, for example in understanding that not having access to the service or particular workers at certain times could stem from commissioning arrangements rather than a culture of not caring, withholding information or punishment.

The ideal model would support individuals to move beyond being a service user to working alongside services as consultants in service user engagement and in the development of services. This would be the ideal way of maintaining contact.

3. Providing a crisis response

Some people with personality disorder can find themselves in crisis quite frequently and all areas should consider people with personality disorder in how they support people with mental health crisis (Department of Health, 2014b). Crisis teams have an obvious role but Street Triage services can also be part of this response. Phone helplines for the public and also those for existing service users can also play a critical role, as long as the staff are trained and have an awareness of personality disorder.

4. Offering practical support

Practical support with everyday issues, such as financial problems, housing, employment and training, and in advocating on the persons' behalf with other services, is really helpful. The latter might take the form of accompanying the person to an appointment. There is a role for peer mentoring and experts by experience in this element. Such interventions can help avert crisis.

5. Multi-agency working

The majority of people with personality disorder in the criminal justice system have multiple and complex needs which can require input from several services at once.

When individuals are in contact with multiple services, it is important these services work with them in an integrated, systematic and consistent way. This is especially important for the majority of people with borderline personality disorder who will not reach the threshold or will not be in contact with specialist services.

In some instances services may either not be aware that they are working with people with a personality disorder or not understand it. Some can be reluctant to work with or use exclusionary criteria against those labeled with a personality disorder. Resistance to work with people with personality disorder is sometimes a result of workers' training gap.

Therefore it is essential that commissioners recognise the need to raise awareness in the wider workforce, recognising that personality disorder and health-related issues are everyone's business. Key agencies coming into contact with both undiagnosed and diagnosed personality disorder include housing, GPs, A&E workers, criminal justice agencies, drug and alcohol services and social care.

A psychologically-informed and knowledgeable workforce is better placed to manage and work effectively with individuals. This can avoid situations escalating and, by the same token, if there are people whose risk and complexity is worrying, workers will be better placed to make appropriate referrals at the right time.

This can be achieved through multi-agency KUF training and multi-agency forums involving the selection of representatives from each agency. Awareness training on mentalisation might also be useful.

Multi-agency teams in specific personality disorder services and functional community teams, whose members spend so many days a week in different teams, are also often able to bridge expertise.

Partnerships between health and criminal justice agencies, as seen in Resettle, are able to link in with probation models of understanding offending and desistance and also health models which are more recovery-oriented thus recognising that no one agency has all the answers.

6. Developing the workforce

Professionals can feel very challenged by some people with personality disorder. Therefore understanding such disorders and the impact they have and how people who live with them can be supported and managed should be a priority.

Training is key to successfully working with people with personality disorder. We would argue that police, probation, court staff and prison officers, but also paramedics and staff in emergency departments should all have basic awareness-level training in personality disorder. Health staff working in these settings, for example psychiatric liaison teams, liaison and diversion teams, prison mental health inreach and

street triage should all have an extended training. Understanding the psychological and emotional needs of someone with personality disorder at the earliest point is likely to lead to a more positive outcome.

There is growing evidence that people with personality disorder can benefit from psychological intervention and provision at the primary care level, via IAPT services, should be geared up and adapted to meet the needs of those with personality disorder.

7. Supporting carers

Skilled carers are a large and largely untapped resource. There needs to be more training and better integration within services for people who care for someone with personality disorder.

Services working with people with personality disorder should also be resourced to support carers.

8. Pre-treatment pathways/interventions

One of the difficulties services have is that people are referred to treatment before they are ready to benefit from it.

Many people arrive at services in crisis – for example following a transfer from prison – and will need some level of crisis planning before they are in a position to engage and benefit from treatment. There should be a pathway for all of those with personality disorder requiring treatment and this treatment should be available along the pathway to allow for continuity.

Accepting a diagnosis of personality disorder can be a big step and it takes time to develop relationships. Preparatory work can include psycho-education and motivational work.

9. Building relationships

Attachment and relationship building are central to working with people with personality disorder and complex needs. All care pathways for personality disorder (including forensic) should have the service user and the therapeutic relationship at the heart of the treatment.

Services that are able to create a social environment, for example, by workers and service users eating together, can reduce the hostility people with personality disorder may feel towards authority. Environments are also important as individuals attach to places as well as people.

Fewer and consistent relationships based on creative approaches to communication and rapport-building help to promote open and honest dialogue around issues such as diagnosis.

Psychologically-informed practice should underpin all service delivery and workforce development. This should include a focus on people's strengths to counterbalance systems and agencies which focus overwhelmingly on the negative. Small goal setting can help to emphasise the positives.

10. Reducing social isolation

It is common for people with personality disorder returning to the community after a prison sentence to experience social isolation and emotional loneliness. Social isolation is associated with re-offending as well as poor mental wellbeing.

It is important to feel connected to other people and have the opportunity to express emotions or day-to-day challenges. Some people with personality disorder may

not have an outlet in the form of family or friends and therefore it is necessary to find that in the community in a safe way.

Supporting integration back into the community, volunteer mentoring and increasing an individual's quality of life and stake in society have strong links with desistance and recovery.

Many people need practical support to aid independent living when moving from approved premises into independent accommodation, for example. It is important that this support is maintained as there can be numerous challenges connected with addressing skill deficits and asking for help with seemingly simple tasks such as washing, cooking and budgeting.

People with personality disorder want to be seen and understood as normal. Volunteer mentors are able to help reduce stigma, build self-esteem and confidence and improve an individual's quality of life. Mentoring can challenge perceptions on both sides and identifying similarities can help build a mentee's aspirations. Volunteers are also able to focus on the strengths of a person and do not take an individual for their label. This is an alternative approach to many of the dominant systems and services which have predominantly focused on the negatives.

11. Services should not mirror the negative attachment histories of their clients

If a person presents to services with extremes of emotions and behaviour and ways of relating, staff often respond by being equally extreme in their responses and emotional reactions.

Services should be conscious not to reinforce certain behaviours, e.g. self-harming behaviours or hostility. In some instances service users will get more input the more they display these behaviours and become socialised to expect it.

From a criminal justice perspective, where an individual has the capacity to be responsible for their actions, it is counterproductive for agencies not to apply parity of justice as it is likely to lead to re-offending and entrench a sense of being different from other people.

Conclusion: A personality disorder pathway throughout the justice system

The Commission's research has identified a clear and significant need for better support for people with personality disorders at every stage of the criminal justice system. We recommend that health and criminal justice services work together, with partners, to provide effective support at each stage, from early intervention to resettlement and that effective pathways should respond to an individual's particular needs, for example their gender, age and ethnicity.

An effective pathway should include these elements:

Community

- Use of the Knowledge and Understanding Framework to raise awareness among community mental health and a whole range of other workers;
- Investment in community-based personality disorder services, using effective therapeutic approaches such as DBT and MBT;

Early intervention

- Very early intervention for 'at risk' children (manifesting marked behavioural difficulty) and their families;
- Specialist support for young people with emerging personality disorder or otherwise 'at risk', for example drawing from the work of organisations like MAC-UK;

Police and courts

- Provision of liaison and diversion and street triage in all police forces;
- Community-based support for offenders with personality disorder, for example

drawing from the Milton Keynes pilot mental health treatment requirement service;

Prisons

- Expansion of the Offender Personality Disorder Strategy to all prisoners with personality disorder;
- The use of psychologically informed physical environments (PIPEs) in prisons;
- Provision of psychological therapies that address the needs of prisoners with personality disorder;

Secure mental health services

- Secure services need to offer specific approaches to patients with personality disorder, particularly to women;

Probation and resettlement

- Probation officers should be trained in the Knowledge and Understanding Framework;
- Multi-agency support for offenders with complex needs, drawing on the Resettle approach;
- Mentoring and peer support to offer practical and emotional support.

References

- American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5)*. Arlington: American Psychiatric Association.
- Bateman, A. & Fonagy, P. (2008) Eight-year followup of patients treated for borderline personality disorder: mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry*. 165:631–638.
- Bateman, A. & Fonagy, P. (2009) Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry*. 166:1355–1364.
- Bateman, A. & Fonagy, P. (2010) Mentalization based treatment for borderline personality disorder. *World Psychiatry*. 9(1): 11–15.
- Centre for Mental Health (2014) *Young adults (18-24) in transition, mental health and criminal justice: Bradley Commission briefing 2*. London: Centre for Mental Health.
- Centre for Mental Health (2012) *Briefing 45: Probation services and mental health*. London: Centre for Mental Health
- Coid, J., Ullrich, S., Keers, R., Bebbington, P., DeStavola, B., Kallis, C. & Donnelly, P. (2013) Gang membership, violence, and psychiatric morbidity. *American Journal of Psychiatry*, 170(9), 985-993.
- Department of Health (2002) *Personality disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder*. London: Department of Health.
- Department of Health (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available at: <http://www.centreformentalhealth.org.uk/the-bradley-commission-five-years-on>
- Department of Health (2014a) *Meeting the challenge, making a difference: Working effectively to support people with personality disorders in the community*. London: Department of Health.
- Department of Health (2014b) *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis*. London. Department of Health. Access via <https://www.gov.uk/government/publications/mental-health-crisis-care-agreement>
- Department of Health & Ministry of Justice (2012) *The offender personality disorder strategy – summary v4 October 2012*. London: Department of Health.
- Dimeff, L. & Linehan, M. (2001) Dialectical Behavior Therapy in a Nutshell. *The Californian Psychologist*. 34: 10-13.
- Durcan, G. (2014) *Review of Sections 135 & 136 of the Mental Health Act: The views of professionals, service users and carers on the codes of practice and legislation*. London: Centre for Mental Health.
- Durcan, G., Saunders, A., Gadsby, B. & Hazard, A. (2014) *The Bradley Report five years on: An Independent review of progress to date and priorities for further development*. London: Centre for Mental Health.
- Fox, E., Krawczyk, K., Staniford, J. & Dickensa, G. (2014) A Service Evaluation of a 1-Year Dialectical Behaviour Therapy Programme for Women with Borderline Personality Disorder in a Low Secure Unit. *Behavioural and Cognitive Psychotherapy*. Published online: 13 February 2014
- Khan, L., Brice, H., Saunders, A. & Plumtree, A. (2013) *A need to belong: what leads girls to join gangs*. London: Centre for Mental Health.
- Long, C., Dolley, O. & Hollin, C. (2014) Personality disordered women in secure care: a treatment evaluation. *Journal of Criminal Psychology*, 4 (1), 44-58.
- Prison Reform Trust (2014) *Bromley Briefings*

Prison Fact file Autumn 2014. London: Prison Reform Trust.

Royal College of Psychiatry (2013) *Enabling Environments Standards*. London: Royal College of Psychiatrists.

Rutherford, M. (2010) *Blurring the Boundaries: The convergence of mental health and criminal justice policy, legislation, systems and practice*. London: Sainsbury Centre for Mental Health.

Singleton, N., Meltzer, H. & Gatward, R. (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office for National Statistics.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. & Meltzer, H. (2001) *Psychiatric Morbidity among Adults Living in Private Households, 2000*. London: Office of National Statistics.

Turley, C., Payne, C. & Webster, S. (2013) *Enabling features of Psychologically Informed Planned Environments*. London: Ministry of Justice.

Members of the Commission

- Rt Hon Lord Bradley of Withington PC
- Eric Allison - Prisons Correspondent, The Guardian
- Chief Constable Simon Cole - ACPO Lead for Mental Health and Disability
- Sean Duggan - Chief Executive, Centre for Mental Health
- Lady Edwina Grosvenor
- Commander Christine Jones, Metropolitan Police
- John Lock JP - Magistrates Association
- Gen the Lord Ramsbotham GCB, CBE - former Chief Inspector of Prisons
- Jenny Talbot OBE - Care Not Custody Director, Prison Reform Trust

The Bradley Commission

Briefing 3: Personality disorder and complex needs

Published October 2015

This briefing was written by
Dr Graham Durcan and Anna Saunders.

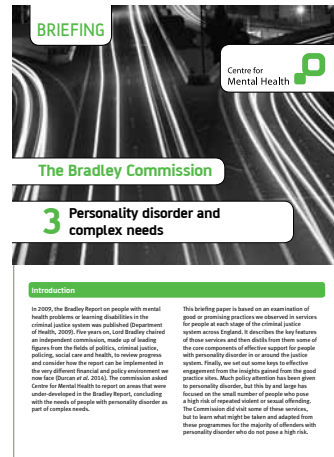
Photograph: iStockPhoto.com/theprint

£5 where sold

© Centre for Mental Health, 2015

Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.

Register for our monthly email bulletins and copies of new briefing papers at www.centreformentalhealth.org.uk



Centre for
Mental Health



Realising a better future

Centre for Mental Health
134–138 Borough High Street, London SE1 1LB

T 020 7827 8300

F 020 7827 8369

www.centreformentalhealth.org.uk

Charity registration no. 1091156. A Company limited by guarantee registered in England and Wales no. 4373019.