RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

CR214

Personality disorder in Scotland:

raising awareness, raising expectations, raising hope.

COLLEGE REPORT

College Report CR214

August 2018
Approved by: The Policy and Public Affairs Committee (PPAC)
Due for revision: August 2023

College Reports constitute College policy. They have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

Contents

Glossary

A&E	Accident and Emergency
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behaviour Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSPD	Dangerous and Severe Personality Disorder
ED	Eating Disorder
GP	General Practitioner
ICD	International Classification of Diseases
ID	Intellectual Disabilities
MBT	Mentalization Based Therapy
NES	NHS Education for Scotland
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PD	Personality Disorder
SPDN	Scottish Personality Disorder Network
STEPPS	Systems Training for Emotional Predictability and Problem Solving

This document will talk about **personality disorder (PD)** in general, as it is likely that many or all of the categories of personality disorder will disappear from the new International Classification of Diseases, in favour of an overall general category of “personality disorder”.

This document will have particular emphasis on the current concept of borderline (or emotionally unstable) personality disorder, as this presentation is common, and currently has the greatest evidence in relation to treatment.

This document will utilise the term **borderline personality disorder (BPD)**, rather than emotionally unstable PD, as this is the term most commonly used in the public domain.

1. Aims

The aims of this publication are to:

- describe current provision of mental health services for people with a diagnosis of personality disorder in Scotland
- provide a consensus view, endorsed by the Royal College of Psychiatrists in Scotland, on good practice for services providing care for people with a diagnosis of personality disorder
- contribute to better understanding of personality disorder and reduce stigma, whilst acknowledging there may be different views about this diagnosis
- describe current models of staff training
- describe examples of good practice in Scotland
- make recommendations for government and health boards on developing good services.

2. Background

The Royal College of Psychiatrists in Scotland Executive Committee identified personality disorder as a priority at the Strategy Day held in 2016. It was felt this group of patients is generally not well served by mental health and other services, despite a number of UK and Scottish documents over the past 15 years which have highlighted the challenges in providing good care for this patient group, as well as describing good practice. It is striking that the 2003 National Institute of Mental Health (NIMHE) document "Personality Disorder, no longer a diagnosis of exclusion"[1] considered it necessary to specify as one of its aims that PD patients should be seen as being part of the legitimate business of mental health services. Despite progress in refining psychotherapy treatments, and improved understanding of the development of PD and good principles of care, it is not clear that this aim has been achieved.

A short-life working group was established, with representatives from faculties within the Royal College of Psychiatrists in Scotland who identified themselves as having an interest in improving care for individuals with this condition. We also invited others from various professional backgrounds (Nursing, Psychology, Allied Health Professions, Police, Criminal Justice, Social Work, and Art Therapy), the chair of the Scottish Personality Disorder Network and people with lived experience of the diagnosis. The working group has met on eight occasions and has utilised a conference hosted by the Scottish Personality Disorder Network (SPDN) to gather wider stakeholder views from across Scotland. The working group has also conducted a survey of current provision of services for people with personality disorder in Scotland and a survey of training models utilised across Scotland. The group has reviewed existing documents, including National Institute for Health and Care Excellence (NICE) guidelines on borderline and antisocial PD, NHS England good practice guidance ("Meeting the challenge; making a difference"[2]) and available evidence regarding treatment (Cochrane review[3][4], Cristea 2016[5]).

Scottish Government Mental Health Strategy 2017–2027

There is no specific mention of personality disorder in the Scottish Government Mental Health Strategy 2017-2027[6], however, the following actions are particularly relevant to this group:

- Action 5: Ensure the care pathway includes mental and emotional health and wellbeing, for young people on the edges of, and in, secure care.
- Action 6: Determine and implement the additional support needed for practitioners assessing and managing complex needs among children who present a high risk to themselves or others.
- Action 8: Work with partners to develop systems and multi-agency pathways that work in a coordinated way to support children's mental health and wellbeing.
- Action 10: Support efforts through a refreshed Justice Strategy to help improve mental health outcomes for those in the justice system.
- Action 13: Ensure unscheduled care takes full account of the needs of people with mental health problems, and addresses the longer waits experienced by them.
- Action 15: Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite and to our prisons.
- Action 24: Fund work to improve provision of psychological therapy services and help meet set treatment targets.

Recommendation

1. Personality disorder should be a priority for the Scottish Government, with inclusion of specific actions in the Mental Health Strategy relevant to improving experiences of care and outcomes.

3. Key messages

Throughout the development of this report, a number of key messages were identified. Consideration of these key messages should be seen as forming the basis of good practice in understanding, treating and living with personality disorder.

- **PERSONALITY DISORDER is COMMON and COSTLY**. Personality disorder is a common condition which is costly in terms of its impact on people's lives, and in terms of the health and wider social costs of functional impairment.

- **PARITY of ESTEEM**. People with a diagnosis of personality disorder are no less deserving of care than people with other mental disorders. Working in mental health means working with people with personality disorder, as this is a common condition, often present alongside other mental disorders.

- **STIGMA** around the diagnosis of personality disorders needs to be challenged, both within staff groups, and in the public perception of what personality disorder means.

- **DIAGNOSIS**. People are entitled to expect a collaborative process of reaching and discussing a diagnosis, which should include a formulation and plan for care.

- **HOPEFULNESS**. There are effective therapy models for the specialist treatment of people with personality disorder. There are common factors from these models which can be utilised by staff in all agencies in providing good general care.

- **RECOVERY** is possible.[1]

- **STAFF TRAINING and SUPPORT**. It is recognised that working with individuals with personality disorder can be challenging for mental health staff. High levels of emotional distress and concern about risk can have a serious impact on staff. Staff knowledge, empathy and skills in all settings can be improved with training, support and appropriate supervision.

- Staff should demonstrate core attitudes of **COMPASSION**, **CURIOSITY and EMPATHY** towards people with a personality disorder diagnosis.

1. "What is Recovery?" The Scottish Recovery Network highlight on their website: " People can and do recover from even the most serious mental health problems. Recovery means being able to live a good life as defined by the person with or without symptoms."

- Services for people with personality disorder should be **TRAUMA-INFORMED**, as described in the NES Knowledge and Skills Framework.

    - **SPECIALIST and GENERAL MENTAL HEALTH** services are important. Most people with a diagnosis of personality disorder will receive most of their care in primary and secondary mental health settings (GP, community mental health teams). Contact with services should do no harm.

    - **JOINT WORKING BETWEEN SPECIALIST TEAMS**. People with overlapping needs (for example, those with intellectual disabilities or co-morbid addiction or eating disorders) should also be able to access appropriate treatment for personality disorder.

    - **MULTI-AGENCY CONSISTENCY**. Consistency of approach within teams and between different organisations is a key factor in good service provision.

    - **EMPOWERMENT and PARTNERSHIP** – "Do with, rather than do to"; people with a diagnosis of personality disorder should be empowered to contribute to their own self-management in partnership with mental health providers.

    - **EARLY INTERVENTION** to identify and treat adolescents at risk of developing personality disorder to prevent progression to an adult diagnosis.

4. Why is personality disorder important?

What is personality disorder?

Personality disorder (PD) is usually defined as a deeply ingrained and enduring pattern of behaviour and inner experience. This affects thinking, feeling, interpersonal relationships and impulse control, and leads to significant functional impairment and distress. These patterns tend to affect all areas of life and functioning, and tend to be inflexible and long-lasting.[7][8]

How common is personality disorder?

The prevalence in the general population of all personality disorders is 6-10%.[9][10] In specialised psychiatric care this figure rises to approximately 50%.[11] Community prevalence is equal in males and females, but there is a higher prevalence in females in the clinical population, perhaps due to increased help-seeking.

The prevalence of PD is estimated at up to 25% of those in contact with primary care[12], and up to 50% of those in out-patient psychiatric contact.

Prevalence/under-reporting?

Personality disorder is present in up to 50% of those in contact with specialist psychiatric services. However, it has been well described that there is significant underdiagnosis of personality disorder in these settings, with less than 8% of all psychiatric hospital admissions recorded as having a personality disorder.[10][13]

Risk of self-harm and suicide

Personality disorders are associated with considerable morbidity, including a high rate of deliberate self-harm, and a considerable lifetime risk of completed suicide. It is estimated that 75% of people with borderline personality disorder (BPD) engage in deliberate self-harm,

and lifetime suicide risk in BPD is estimated between 8% and 10%, and in dissocial/antisocial PD is estimated at 5%. Particular risk has been described around the time of first diagnosis.[14]

Co-morbidity with other mental disorders

In addition to the risk of self-harm and suicide, there is evidence that a diagnosis of personality disorder is strongly associated with the diagnosis of other mental disorders, in particular anxiety disorders, affective disorders and substance misuse disorders.[9] Having a PD diagnosis also predicts a worse outcome and response to treatment[15], increases the risk of suicide in people with co-morbid mental disorders[16] and increases the risk of persistent and addictive drug use.[17]

Physical health and personality disorders

People with a diagnosis of PD have higher morbidity and mortality rates than those without this diagnosis. Life expectancy is 18–19 years shorter.[18] Likely mechanisms for this include higher self-harm and suicide risk, in addition to a higher incidence and mortality rate from cardiovascular and respiratory disease.[19][9]

Difficulties managing relationships with services and professionals may contribute to problems accessing appropriate help with physical health conditions, and the high prevalence of smoking and substance misuse are likely to be contributing factors.

Service users often describe difficulties interfacing with health professionals about physical healthcare needs, finding they are often discriminated against because of their personality disorder diagnosis. For example, being told that physical symptoms are “all in your head”.

Socio-economic cost of personality disorder

A personality disorder diagnosis is also associated with significant functional impairment, including low educational achievement, low income, conflict at work and unemployment.[20][21] A number of studies have found significant loss of days of productive role functioning and social role functioning in people with a PD diagnosis. This functional impairment tends to persist over time[22], and remains relatively resistant to treatment.

Individuals with a diagnosis of PD utilise more general practice, medical and psychiatry services, than those without this diagnosis,[23][9] Estimates of direct healthcare costs and indirect loss of functioning costs are greater than for depression and generalized anxiety disorder (GAD), and comparable to schizophrenia.[23]

A particular challenge for staff: The need for psychological awareness

A number of documents and writers have emphasised the particular challenge of offering services to this group of patients. Models of understanding include attachment theory and psychodynamic theories, which help to conceptualise the interpersonal and organisational challenges of working with a patient group who may have profound difficulties in the way they form and manage relationships and emotions. Challenges include strong emotional responses in staff (either positive or negative), extreme differences in emotional responses between staff within a team, and sometimes differences in responses between organisations. When not recognised, this can lead to potential difficulties maintaining professional boundaries and consistency of care.

It is essential to best care that staff have access to training on appropriate care and treatment for people with a diagnosis of PD, and for staff to engage in reflective practice.

5. Definitions and controversies surrounding personality disorder

A simple definition of personality disorder can be summarised as the **three Ps**. For the diagnosis of personality disorder, the symptoms must be:

- **Problematic** (outside the norm for the society in which they live, a source of unhappiness for the person and to others, and to severely limit them in their lives)
- **Persistent** (a chronic condition over a long period of time, usually emerging in adolescence and continuing into adult life)
- **Pervasive** (there are difficulties in all areas of the person's life, and how they react to the world around them. For example, work, family and relationship to sources of help may all be difficult).

One of the constants in the field of personality disorders is controversy over the conceptualisation of the disorder, definitions and language used. This has been evident over recent years in relation to discussions about classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) in the USA, and the International Classification of Diseases (ICD). There have been differing professional views about whether there should be defined separate categories of personality disorder, or whether personality should be described on a spectrum of traits. Some proposals include both a categorical and dimensional component to classification.

The latest iteration of the DSM classification of personality disorders removed the distinction between personality disorders and other mental disorders, by removing the separate classification system of Axis I and Axis II disorders. Personality disorders are now classified alongside other mental disorders. Otherwise, the classification remains largely unchanged.

The current proposal for ICD-11 is to replace the existing categorical system with an initial simple scheme for diagnosing whether personality disorder is present, and then categorising the severity, using measures of functional impairment. There will then be an assessment along

different personality trait dimensions, which is still to be finalised. This will allow for each individual to be described more precisely, including the degree of impairment in functioning in different domains. However, loss of current categories such as "borderline" and "antisocial" may make it less easy to predict who might benefit from therapies which were developed around these concepts. A compromise solution is currently being considered by the World Health Organisation (WHO). This will involve utilising the trait and severity model with the addition of a borderline pattern qualifier, so that people can still utilise the descriptive diagnosis of borderline PD, where appropriate. This will also allow patients, clinicians and researchers time to adapt to the new trait model of classification.

Box 1: ICD–10: Definition of personality disorder:

1. **A personality disorder is an enduring pattern of inner experience and behaviour. This pattern manifests in two or more of the following areas:**
   a Thinking
   b Feeling
   c Interpersonal relationships
   d Impulse control.
2. **This pattern deviates markedly from cultural norms and expectations.**
3. **This pattern is pervasive and inflexible.**
4. **It is stable over time.**
5. **It leads to distress or impairment.**

Personality disorder subtypes, as listed in ICD-10 and DSM-V[7][8]

ICD-10	DSM-V
Paranoid	Paranoid
Schizoid	Schizoid
Schizotypal*	Schizotypal
Dissocial	Antisocial
Emotionally unstable, borderline type	Borderline
Emotionally unstable, impulsive type	
Histrionic	Histrionic
	Narcissistic
Anxious	Avoidant
Dependent	Dependent
Anankastic	Obsessive-compulsive
Other specific personality disorders and Mixed and other personality disorders	Personality disorder, not otherwise specified

* ICD-10 schizotypal disorder is consistent with DSM-V schizotypal personality disorder but in ICD-10 is included within the section of schizophrenia, schizotypal, and delusional disorders.

Problems with the current categorical system include:

- two people can meet criteria for a particular PD diagnosis, each with a very different range of presenting features
- many people meet criteria for more than one PD diagnosis
- many people with a PD diagnosis also meet criteria for other mental disorders.

There are also different views amongst service users, carers and professionals about the use of the diagnostic label of PD at all. Some feel it to be a label that is judgemental of a person's whole personality and having this label subjects individuals to negative attitudes and responses from services (see the "PD in the bin" movement[24]). Others hold the view that it is helpful to have a recognised diagnosis which may lead to meaningful engagement with services and appropriate treatment, but that stigma still exists and should be challenged. There are also models being developed which describe alternatives to diagnosis, as outlined recently in a British Psychological Society publication, "The Power Threat Meaning Framework".[25]

These different views are clearly articulated in the poems below.

On being diagnosed with BPD:

Response A	**Response B**
Call me what you want	Don't insult the core of who I am
But give me choice of treatment	Don't condemn me to being damned
Give me hope, I don't want more pills	Don't project your failures on to me
Teach me skills, to help me cope	Don't cage me with pathology
Validate me, treat me fair	Don't compound the hurt and shame
Understand me, show me care	By making out that I'm to blame

Poems by Sally Fox and Jo McFarlane, from Stigma and Stones[84]

This group accepts there are limitations to these diagnostic systems, and stigma still exists towards people who have been given this diagnosis. However, we also acknowledge the evidence which currently exists for treatments has been based on these categories, and therefore the most pragmatic approach is to use this framework until something else is clearly established. Work should continue to improve understanding of personality disorder, and to refine concepts and treatment options. Stigma should be challenged within mental health services, and in the public domain.

Diagnosis and formulation

Despite the controversies and discussions noted above, this paper endorses the practice of making a diagnosis collaboratively with each individual, including a full formulation of their particular situation. This should include an assessment of the person's strengths and areas of difficulty and be linked to a shared treatment plan with short and longer-term goals.

Making a diagnosis of personality disorder relies on an understanding of the person's presentation over a significant period of time, and ideally with involvement of family, friends or others who know the individual well. It is important to establish a pattern of personality traits and functioning over time and in different circumstances. A diagnosis should not be made on the basis of a single interview with a person in a distressed state.

It could be considered discriminatory **not** to make a diagnosis, as this may prevent the individual from accessing appropriate information about the disorder, pathways to evidence-based care and treatment where available, and it leads to under-representation of this mental health diagnosis in healthcare planning and policy.

Diagnosis should be seen as the start of a process, a process which allows for review and change over time. It is important to note the course of a personality disorder might mean that in time, a person may no longer meet criteria for the disorder.

Consensus on how personality disorder develops

Development of each personality is a unique combination of genetic factors and biological vulnerability, together with early childhood experiences and wider environmental and social factors.

Most experts in the field subscribe to the biopsychosocial model for understanding the development of personality disorder.

This means that personality disorder develops as a result of interactions between:

- biologically/genetically determined vulnerabilities
- early experiences with significant others (attachment experiences)
- the role of social factors in buffering or intensifying problematic personality traits.

Boxes 2 and 3 briefly summarise two theoretical models which have been influential, and form the basis of two of the most widely available therapy models.

Box 2 – Invalidating environments

Marsha Linehan, developer of Dialectical Behavior Therapy (DBT) describes a biosocial theory of BPD development. The main premise is that a child's emotional sensitivity interacts and transacts with an invalidating environment over time, contributing to the development of emotion dysregulation, including a reduced ability to label emotional arousal, tolerate distress or trust one's own emotional responses. As adults, people with BPD can adopt the characteristics of an invalidating environment including invalidation of their own emotional experiences, looking to others for accurate reflections of reality and over-simplifying the ease of solving life's problems.

An invalidating environment is one in which communication of private experiences is met with erratic, inappropriate or extreme responses. This gives the child the message that they are wrong in their description and analysis of their own experiences while simultaneously attributing them to socially unacceptable characteristics.

Box 3 – Attachment and mentalizing

Mentalizing is a concept described by Bateman and Fonagy, which can be described as the capacity to make sense of one's own and others' subjective states and mental processes.

The capacity to mentalize is thought to be a major developmental achievement, which happens in the context of the caregiver's emotionally-attuned responses to the infant within a secure attachment relationship. According to this mentalizing model, all of us are likely to lose our capacity to mentalize temporarily under stress.

The capacity to mentalize is thought to be particularly fragile in borderline personality disorder, due to early experiences of insecure disorganised attachment, lack of sensitive and emotionally-attuned responses to emotional states in the infant, and in some cases experiences of maltreatment and neglect. People with a diagnosis of borderline personality disorder typically lose their capacity to mentalize more easily and rapidly in the context of interpersonal interactions and have more difficulty re-establishing mentalizing when it is lost. This can result in frequent, rapid and easily provoked lapses in mentalizing, where the person reverts to pre-mentalizing modes of functioning. This can include 'mis-reading' others' minds and intentions, seeing things in black and white terms, or being certain about what is in other people's minds, particularly when emotionally aroused.

Trauma and adverse early experience

One of the factors which may contribute to the development of personality disorders is early life trauma and neglect. It has been shown that early life Adverse Childhood Experiences (ACEs) have a broad "dose-related" effect on multiple social, educational, physical and mental health outcomes[26]. More specifically, people with a diagnosis of BPD are significantly more likely than people with other personality disorders to report having been emotionally and physically abused by a caretaker and sexually abused by a non-caretaker.[27] They were also significantly more likely to report having a caretaker withdraw from them emotionally, treat them inconsistently, deny their thoughts and feelings, place them in the role of a parent, and fail to provide them with needed protection. When all significant risk factors were considered together, four were found to be significant predictors of a borderline diagnosis: female gender, sexual abuse by a male non-caretaker, emotional denial by a male caretaker, and inconsistent treatment by a female caretaker.

These results suggest that sexual abuse is neither necessary nor sufficient for the development of BPD, and that other childhood experiences, particularly neglect by caretakers of both genders, are significant risk factors.

Services for people with personality disorder should therefore be trauma-informed, as described in the NES Knowledge and Skills Framework[28], whilst also recognising that not all people with a diagnosis of PD will have experienced such events in their history.

The trauma-informed principles of choice, collaboration, trust, empowerment and safety overlap significantly with the core approach being described in this document in relation to people with a diagnosis of personality disorder.

Personality disorder in childhood and adolescence – A Child and Adolescent Mental Health Service (CAMHS) perspective

Adolescence is usually considered a time of change and development. It is a developmental stage characterised by impulsivity, emotional and psychological changes, rapid mood swings and risk-taking behaviours.[29] Dramatic changes take place within the brain and in behavioural patterns of adolescents. Until recently, the diagnosis of a personality disorder in a young person was associated with controversy, and it still can be. There are a number of reasons for this reluctance to make a diagnosis, including the perception that personality is unstable in adolescence; the stigma attached to a diagnosis and the idea that the symptoms described could be better attributed to other mental health diagnoses.[30]

Focus on borderline personality disorder

The rates of BPD in adolescents are estimated at 1–3% in community samples, 11% in out-patient samples and greater than 40% in in-patient samples.[31] A diagnosis of BPD in adolescence is associated with increased rates of hospitalisation[32] and more severe symptoms of other mental health disorders such as depression.[33]

Developmentally, the genetic studies completed in adolescents show similar results compared to studies completed in adults, with a suggestion that as people get older the impact of genetic influences is greater.[31] The scanning literature has reported differences in the orbitofrontal cortex and anterior cingulate cortex. There are functional abnormalities seen in the brains of adolescents with a diagnosis of BPD as the pathways involved in emotional regulation do not develop as expected.[31]

Once a young person has been diagnosed with BPD there is considerable stability in the diagnostic thresholds. In a study of young people who had committed a suicidal act and were assessed in an emergency department, those who met diagnostic criteria for BPD at age 14 were eight times more likely to meet diagnostic criteria at age 18 than those who did not meet criteria at age 14.[34] This study also suggests people with a diagnosis of BPD are likely to first attempt suicide in adolescence, therefore these acts present a valuable clinical opportunity to intervene and change clinical trajectories. Sadly, these opportunities are sometimes missed for a variety of reasons including staff training.

Making a reliable diagnosis in adolescence

Interviews and scales have been developed internationally to allow for a reliable diagnosis of BPD to be made in adolescence in some populations. These scales have not been validated in a UK population. One such scale is the Personality Inventory for DSM-V which uses a dimensional approach to diagnosis. This scale has been translated into various languages and there have been reports of good reliability and validity in in-patient population[29] and younger children.[35] The childhood interview for DSM-IV BPD was used in in-patients that were mostly white middle class females, which showed good validity. There appears to be some evidence that there is little correlation between self-report and clinical interviews to make the diagnosis, suggesting that self-reporting is less effective for diagnostic purposes.[36] Making a diagnosis in young people should ideally involve multiple sources of information and observation of a sustained constellation of symptoms over time, and not rely on single interviews or self-reports.

Making a diagnosis has the value of offering an explanatory framework for young people and those caring for them, and most importantly can support them in accessing effective therapeutic interventions. There

are several studies showing that careful diagnosis and time-limited interventions can result in significant reduction in symptoms and suffering.[37]

Course of personality disorder

There is good evidence that there can be significant recovery and remission from the symptoms of borderline personality disorder over time, even without specialist intervention. A 10-year prospective follow-up study showed that there was sustained remission (no longer meeting criteria for BPD for at least 4 years) for 30% of the sample at 4 years, rising to 50% at 10 years' follow up.[38] This demonstrates a more hopeful picture of the course of BPD over time.

It is important to note however, that a relatively high degree of social and vocational functional impairment persists, despite remission of symptoms.

Box 4 – Recovery story

I found living with borderline personality disorder a real struggle and hardship while I was young. It took me 20 long years to start my recovery journey. Getting to know myself and learning about my illness really helped. Having a therapist who believed in me and held that hope was the start. I realised I had to take personal responsibility and control my own destiny. Routine, healthy eating, exercise and good sleep routines promoted wellbeing. While my family and friends were a great support, writing My Wellbeing Recovery Action Plan (WRAP) played a huge part in my recovery. Meaning and purpose was key to everything, as voluntary and then paid work rebuilt my self-esteem and confidence. I have healthy coping strategies for all symptoms and difficulties from my mental illness. I now work as a peer worker and I share my experience to offer hope. I build mutual peer relationships and share coping strategies. My 20 years of uphill struggles is now put to good use in a positive way by empowering others to recover too. Recovery to me, meant getting my self-respect back and leading a normal family life.

Fiona Gray, Peer Worker at Penumbra

6. Treatment and care for people with a diagnosis of personality disorder – what works

Although there is ongoing debate surrounding the definition of personality disorder, there is growing evidence for effective treatment and general principles of good care for people with this diagnosis. This section outlines the consensus statement on good general psychiatric care for those with PD, as well as descriptions of effective therapeutic models.

6.1 Consensus statement on good general psychiatric care

General psychiatric care/managing risk

Most people with a diagnosis of PD will access services mainly in primary and secondary mental health settings, such as from their GP or the community mental health team. The principle of any contact with services is that this should do no harm.

Unfortunately, experiences of care are variable for many people. Experiences include inconsistent approaches, not receiving information about the diagnosis, variable access to specialist services and long waiting times, as well as an experience of undertrained staff with varying attitudes towards individuals with this diagnosis.

The key functions that good general psychiatric care should provide are:

- Assessment and diagnosis
- Providing information to individuals and their families
- Development of treatment alliance
- Agreement of achievable short and long-term goals
- Crisis planning in partnership with the individual

- Risk assessment and risk management
- Medication review and rationalisation
- Monitoring of physical health needs
- Stabilisation of substance misuse
- Involvement of families/partners where possible
- Development of an initial formulation
- Consideration for referral to specialist therapies where available.

Consensus is also developing regarding some general principles and attitudes which underlie the delivery of good care. These have developed from the effective psychotherapy models. These general principles can be adopted and supported within any organisation, without the necessity for full training in a theoretical model. The literature on converging principles of good general care, emphasise a coherent theoretical stance shared by all staff and patients as key to their success.[39]

- Coherent theoretical stance
- Clinicians who choose to work with people with PD
- Clinicians who are hopeful that people can recover
- Clinicians who are able to form treatment alliance with shared goals
- Clinicians who demonstrate empathy and validation of patient's experience
- Treatment is well structured
- Team culture of supervision
- Skills in managing suicidality and risk.

One model which has been utilised to organise care for people with a PD diagnosis, is the Phases of Treatment model.[40] This conceptualises different phases of treatment:

- Safety and stabilisation phase
- Exploration and change phase (making sense)
- Integration and synthesis phase (making connections).

In personality disorder, people can present with such a range of difficulties that it can be challenging to know which should be addressed first. This approach offers a framework for people to be supported to work through the different phases as appropriate.

Risk

Risk of self-harm, suicide and aggression are challenges for services in terms of knowing how best to respond. The general aim of most treatment is to help the individual develop better skills and capacity to manage their emotional dysregulation, and to find more adaptive strategies. There is no clear evidence that long-term hospital admission for treatment of personality disorder is helpful.[41] There is general consensus in the clinical literature that long-term hospital admission is likely to be harmful, as it may work against the long-term aims of developing skills to manage distress.

Crisis planning

Joint crisis planning has been shown to have high face validity as it is likely to promote an increased sense of control over problems and improved relationships with mental health professionals.[42]

Evidence-based therapies all include collaborative crisis planning as one of their core components, as this is generally considered to be an important tool in empowering people to develop skills to manage their own distress. The Distress Brief Intervention approach has also shown people in distress require improved coordination across agencies, quicker access to support and more consistency in the compassion they receive.[43]

Recommendation

2. Crisis plans for patients with personality disorder should be developed and shared between relevant service providers.

Examples of crisis management plans will be made available on the Royal College of Psychiatrists in Scotland's website (www.rcpsychis.org.uk).

There are times when the acute risk of harm is judged to be high. At these times it is a difficult task for staff to judge whether to act to contain this immediate perceived risk, or whether to adopt "positive risk taking" and tolerate the risk.

The potential benefits and dangers of these responses have been described as follows[44]:

Action	Consequence				
	Potential benefit	**Potential danger**	**Potential short-term impact**	**Potential long-term impact**	**Potential interpretation of clinician motive**
Tolerate risk	Patient autonomy	Clinician complacency/ patient suicide	Short-term risk	Long-term autonomy	Neglect of patient
Contain risk	Patient safety	Patient dependence	Short-term safety	Long-term dependency	Care and compassion

Each situation will always have to be assessed according to the individual, their particular needs and their circumstances. However, this model may help weigh up the potential risks and benefits.

Several published guidelines[45][46][39] recommend only brief admissions when other community options, such as involvement of crisis teams/ intensive home treatment teams, have not been sufficient to meet the current needs.

Admission should be a team decision and take into account the individual's wishes, as well as the opinion of family and carers as part of the overall treatment plan. Some reasons for consideration of in-patient admission may be:

- Management of crises, including acute suicide risk/risk to others
- Onset of severe depression or other co-morbidity
- Review and rationalisation of medication
- Detention under Mental Health (Care and Treatment) (Scotland) Act 2003
- Feelings in the clinician (increased anxiety about risk, or hopelessness about failed treatment leading to possible rupture of relationship).

It is best practice to involve the individual in decisions about admission, including:

- Joint understanding of potential benefits and possible harm that may result
- The planned length and purpose of the admission
- Review of whether goals have been achieved
- Plan for discharge.

If no progress is made towards goals, plan for discharge should be discussed on grounds that the intervention of admission has not been successful.

6.2 Therapies

Specialist psychological therapies

Of all personality disorders, the evidence for efficacy of psychological therapy is strongest for borderline personality disorder. Several specially designed adaptations of therapy have been developed and have shown modest Randomised Control Trial evidence of clinical effectiveness.[3][5] It is important to note that although the findings support a substantial role for psychotherapy in the treatment of people with BPD, this is not yet a very robust evidence base, with a relatively small number of studies which require further study and replication.

The current evidence supports:

Specialist treatment programmes	
DBT	**Dialectical Behavioural Therapy**
MBT	**Mentalization Based Therapy**
STEPPS	**Systems Training for Emotional Predictability and Problem Solving**
SFT	**Schema Focussed Therapy**
TFP	**Transference Focussed Psychotherapy** (not widely available in Scotland)

Effective treatments have some qualities in common; they are relatively long term (12–18 months' duration), and most utilise both individual and group therapy. STEPPS is an exception, in that it is a 20-week group programme. These therapies have demonstrated significant improvement in personality disorder-relevant measures such as self-harm, suicide, health service use, hospitalisation and general psychopathology.

These therapies are included in the Scottish Government MATRIX document[47] which has been produced to help NHS boards deliver the range and quality of psychological therapy required to achieve the HEAT Psychological Therapies Access Target.

Patient choice should always be a key factor in choice of therapy modality.

"Generalist" manualised treatment programmes

An interesting development from these studies of specialist therapy is that control group programmes – also often highly structured and manualised, with clinical supervision and high levels of contact with patients – were also shown to demonstrate some effectiveness. However, this has not yet been replicated in trials designed to test these models against treatment as usual.

Manualised generalist treatment programmes	
SCM	**Structured Clinical Management**
GCC	**Good Clinical Care**
GPM	**General Psychiatric Management**

These models meet all of the conditions specified above for good general care and have the advantage of requiring limited staff training. The model of care does require regular individual and group input over a significant period.

Other psychological therapies

Many individuals present with a complex clinical picture which does not clearly fit within a single diagnostic category. For people with mixed personality disorder diagnoses, and PD co-morbid with other conditions, the relevance of evidence for specific PD therapies is less clear.

In these circumstances, it is good practice to complete a comprehensive assessment, including a psychological assessment and formulation. Other models of therapy than those listed above may be considered most appropriate, including individual or group psychodynamic therapy, CAT (Cognitive Analytic Therapy) and Cognitive Behavioural Therapy (CBT) models adapted for use for PD. There is also developing interest in process-focussed and compassion-based therapies. In some cases, it may be more appropriate to consider therapies which develop other forms of communication, for example art therapy or drama therapy.

Pharmacotherapy

There are no medications licensed for the treatment of personality disorder.

NICE guidelines,[45] and other more recently published guidelines,[46] do not recommend primary pharmacological treatment for borderline personality disorder based on the current available evidence.

A small number of randomised control trials have shown mixed and inconclusive results for the use of several classes of drugs for particular symptom groups. These studies have small sample sizes and utilise different outcome measures, adding to the difficulty of reaching a conclusion about clinical effectiveness. Medications often utilised for particular symptom groups are:

- Antipsychotics for impulsivity and aggression and cognitive distortions
- Antidepressants for low mood and anxiety symptoms
- Mood stabilisers for impulsivity and mood dysregulation.

There may be occasions when an individual is seeking symptom relief, particularly if clinical distress is high, when a trial of medication is considered. Any trial of medication should be discussed with the patient, including risk of side effects, the symptoms being targeted and a time-limited trial agreed. If no benefit is observed, this should be discontinued, particularly before any other trial of medication is commenced. Polypharmacy should be avoided.

Although this is generally agreed to be good practice, it remains the case that people with a diagnosis of BPD are often prescribed a number of medications.[48] This discrepancy can be accounted for by some of the psychotherapy models which help explain the powerful emotional impact on staff when in contact with highly distressed individuals. Clinicians may feel a strong need to help or rescue the person from their emotional pain and distress, and may struggle to manage their own feelings such as hopelessness and powerlessness to help. There is a well described phenomenon that an individual with PD may at times feel a need for a concrete demonstration that their distress is being heard and understood, thus demanding action from the professional in response to emotional distress.[49]

Prescribing during crisis

There is no clear evidence for the use of any specific medication for crisis management in personality disorder. Ideally there will be a comprehensive crisis plan in place which will outline possible alternatives, including self-management skills or contact with professionals or services who can help the person utilise non-pharmacological approaches to manage distress.

If prescribing is considered in a crisis, the principles above should be adhered to (harm minimisation and avoidance of polypharmacy) when any short-term prescribing is considered. Ideally, discussion in a multi-disciplinary team, including review of the overall treatment plan and goals may help to weigh up short and long-term risks and

benefits. All crisis prescribing should be short-term and be reviewed at the next scheduled appointment.

Prescribing for co-morbid disorders

All people with a diagnosis of personality disorder should be reviewed in relation to possible co-morbid psychiatric diagnoses. Where this occurs, appropriate treatment should be offered. There is, however, evidence that treatment for depressive disorders is less effective in those with co-morbid PD.[50]

6.3 Special groups

Personality disorder in forensic settings

In forensic settings in Scotland, it is not common to have a primary diagnosis of personality disorder, but comorbid diagnosis is much more common.[51] Having a PD does not make you more likely to be an offender, but it is more prevalent in offenders.[52]

The prevalence of PD in UK male remand prisoners has been found to be as high as 78%.[53] A systematic review of over 60 studies from 12 western countries showed a PD prevalence of 65% amongst offenders, with antisocial PD predominating (47%).[54] Studies have shown a link between cluster BPDs and violence,[55] although the exact causal link between PD and violence is not clear. Despite the increased risk, not all people with PD are violent and the 5-year prevalence of violence in people with PD is 11%, compared to 7% for the population with no mental disorder.[56]

Assessing and managing risk is central to forensic services and a diagnosis of PD has significant implications, with violence risk assessment tools invariably including personality traits as factors. Personality disorder will impact greatly on the formulation process. This is a way to understand the whole person and their offending behaviour, which is a central component of risk assessment, as it provides a framework to help explain the nature and causes of offending behaviour.

Working with personality disordered offenders poses various difficulties for monitoring and supervising staff, due to the nature of the complex underlying interpersonal difficulties experienced by people with PD. A very helpful guide to working with PD offenders has been published by the Ministry of Justice[57] and an online learning resource from this material has been developed in Scotland for NHS Education for Scotland.

A recent position paper from the Forensic Network on psychological approaches to PD highlighted minimum service requirements for all forensic settings, including PD awareness for all staff, the provision of highly specialist therapy for PD, as well as access to reflective practice.[58] The Network has paid particular attention to the management of forensic environments through structured clinical care (SCC) and reflective practice. There are specific Network groups developing papers in relation to these core facets of care for offenders with personality disorder and to help staff manage this complex group.

There have been significant developments in the treatment of PD over the last 15 years including looking at how to help patients with antisocial PD, especially using MBT and CBT. It may be that more systemic interventions directed towards staff, services and organisations – e.g. through SCC – may be the mainstay of helping to manage offenders with a diagnosis of PD. Increasingly, this is a focus of professionals across the Forensic Network in Scotland – looking at helping health, social care and Scottish Prison Service (SPS) staff. This bodes well for the future care and treatment of mentally disordered offenders more generally and for patient–offenders with a diagnosis of PD in particular.

Personality disorder and addictions

Best practice for patients with substance misuse and personality disorder, compatible with Clinical Guidelines on Drug Misuse and Dependence Update, 2017[59]:

- Patients should be offered appropriate drug/alcohol treatment, even if they are not receiving treatment for their personality difficulties.

- Those who are experiencing a psychiatric crisis require assessment and management of the crisis through the locally agreed systems and pathways of emergency psychiatric care.

- If the person is considered to have severe and complex difficulties, they should remain under the care of mental health services for treatment of their personality difficulties and be referred to drug/alcohol treatment services for substance misuse dependence. Avoid a sequential provision of treatment as this risks exclusion and drop-out.

- Patients assessed as having sufficient severity and risk should be considered for complex care planning e.g. CPA. The substance misuse recovery plan can be incorporated into the wider care plan with care co-ordination.

- A patient should not be initially turned away from either mental health services or drug/alcohol services due to their co-existing condition, even if subsequent onward referral is required.

- There should be joint mental health and substance misuse local strategies with joint outcomes supported at the highest level.

- Appropriate clinical competencies within services to allow accurate assessment and treatment or onward referral to the appropriate other service.

- Substance misuse service staff need to be trained and skilled in appropriate assessment, immediate support and onward referral of individuals presenting in distress, crisis and with suicidal thinking. However, substance misuse services are designed for the elective management of dependence and are not staffed to provide acute crisis services. This can create miscommunication between professionals and must not lead to exclusion from the acute and crisis services locally.

- In most geographical areas, self-referral to substance misuse services is usually an option, but direct communication/ referral between services with inclusion of primary care may be preferable, especially with increasing complexity and severity.

Personality disorder in the perinatal period

Women with personality disorder who conceive may face additional challenges both for themselves, and for their pregnancy and child. The need for contact with multiple professionals, often including social services/child protection agencies, during pregnancy and the postnatal period, may cause destabilisation or development of co-morbid anxiety or depression. Women with PD are more likely to have a history of disrupted upbringing with poor attachment experiences, and pregnancy can act as a trigger for bringing distressing memories to the fore.[60]

Although research is limited, there is evidence that people with personality disorders face additional struggles to be successful parents. Where women themselves have difficulty with emotional self-regulation, they may be particularly challenged in creating a stable environment that promotes good attachment for their infant. The quality of the early relationship between primary caregiver and infant has an important influence on neurological, psychological and social development, and on long-term wellbeing for infants growing up.[61] The presence of PD may have an adverse influence on the mother–infant relationship and on infant development. However, this is not

inevitable. In postnatal depression, PD may worsen infant outcomes in terms of dysregulated behavior[62] and security of attachment.[63]

The particular factors that should be borne in mind when working with women with PD in pregnancy and the first postnatal year include:

- Personality disorder should never be a diagnosis of exclusion from services, including specialist perinatal mental health services.

- Pregnancy and the postnatal period bring about unique challenges for women who themselves have poor experiences of being parented. They are therefore more vulnerable during this time and are likely to require more support. This should result in lowering of thresholds for access to services.

- There is often an increased need for psychological approaches during this time period, both to treat the woman and to promote good mother–infant relationships and infant development, not least because of the need for caution in prescribing. For some women, this period may be a time of increased motivation to change. Pregnant and postnatal women should have prioritised access to psychological therapies suited to their needs, including primary care mental health services.

- Other services working with women at this time (including maternity services, health visiting and social services) may themselves require support and education in their approach to, and understanding of, personality disorder. Mental health services have an important role in providing this liaison.

- Good communication between professionals is paramount during pregnancy and the postnatal period, when there may be a number of different agencies and professionals involved in supporting a woman and her family. Transition between services may pose particular challenges for those with PD. Consideration of this, cooperation between services and sensitive care planning involving the woman and her family is likely to be needed to facilitate transition between services.

- As with women with other mental health difficulties, there is a duty on mental health staff to engage all women of childbearing potential, and particularly those on psychotropic medication, in discussion on pregnancy planning and contraceptive advice in advance of pregnancy.

- For all services, the safety and welfare of the infant and other children are paramount, and many women will require assessment and engagement with social services. Mental health services have clear obligations regarding child protection, while ensuring continuing support and engagement for the woman.

Personality disorder in medical settings

- General medical environment: emergency departments and acute medical settings often experience unpredictable demand which engenders pressure on the system and bed shortages, necessitating changes to where patients are admitted, and frequent changes of staffing. This can complicate delivery of unscheduled care to patients with borderline personality disorder, for example by unpredictable, inconsistent communication and abrupt transitions.

- General hospital staff training: staff in the general hospital setting could benefit from training and education to instil hopefulness, modify attitudes by presenting evidence, reducing stigma and enhancing skills in communicating with and supporting patients in crisis. Use of anticipatory care plans can be helpful to smooth the patient journey.

- Psychological therapies delivered by structured out-patient programmes can bring benefit to patients' coping skills and resilience when they are in crisis in the general hospital, e.g. with physical problems.

- Patients with BPD can be more vulnerable to experiencing intolerable pain and distress from physical symptoms. Staff awareness and education can enhance support available and help to reduce iatrogenic harm by excessive investigation or treatment, whilst empathising with the person's experience and offering appropriate support, e.g. chronic pain services.

- Living with BPD, as with any other comorbidity, makes it more difficult to manage another health problem. At times when it undermines self-care, comorbid long-term conditions (e.g. diabetes, renal failure, anticoagulation, cancer etc.) can deteriorate, risking worse outcomes in the long term. It is important to recognise and explicitly discuss how to manage comorbid health problems.

- Staff training might be particularly important for health staff working with patients over a long period to help manage chronic physical conditions, for example dialysis units (small numbers, intense contact for months/years) and diabetes clinics (high number, low intensity contact for years/decades).[64][65]

Personality disorder in intellectual disabilities

There is significant evidence that people with intellectual disabilities (PWID) are susceptible to developing personality disorders. Prevalence figures range from 1% to 92%[66] and 50% in secure

intellectual disability services.[67] The wide prevalence figures reflect the challenges in assessment, diagnosis and application of classification systems. Specifically, the difficulties include the individual ability to self-report symptoms, diagnostic overshadowing, communication skills, dependence on third-party informants, presentation of symptoms and the potential overlap with other psychopathology and behavioural disorders. These difficulties are increased when assessing people with severe and profound intellectual disabilities (ID), so diagnosis is not recommended for this particular group.[68]

The developmental phase for personality characteristics among PWID should be viewed as longer than that of a person of average ability. As such, recommendations are that the diagnosis should be made after the person has reached the age of 21.[68] PWID are also more likely to be wary of strangers or others, to seek guidance and to be dependent on others.[69] Therefore, the diagnosis of schizoid, dependent, anxious (avoidant) PD are generally avoided in this group.[68] Organic personality disorder on the basis of a diagnosis of ID alone or epilepsy is also not thought to be appropriate.[68]

Features of borderline personality disorder, such as self-injurious behaviour, impulsivity and affective lability, occur commonly in ID [70]. Consequently, it is important that additional features should be sought before making this diagnosis.[71]

The Royal College of Psychiatrists (2001) recommend that initial diagnosis using the criteria for personality disorder (unspecified) are met. Following this, further sub-classification should be considered.[68]

Whilst successful treatment programmes have emerged for BPD, little of this has related to the ID population.[72] Those with a diagnosis of PD and ID are also more likely to experience restrictive treatment and placements.[73]

Single number case studies have described pharmacological and behaviour interventions in PWID and BPD[70] and a four-stage model based on DBT.[71] However, the evidence base is yet to emerge – NICE (2015).[45] Therefore, they propose that without a strong evidence base for successful interventions for BPD, those with mild ID should have the same access to mainstream services, working closely with ID services.[45]

Eating disorders and personality disorder

Co-morbidity of eating disorders and personality disorders is high. A recent meta-analysis[74] showed that the mean proportion of PD among patients with any type of eating disorder was 0.52 compared to 0.09 in healthy controls. In more severe cases, patients often meet criteria for several different personality disorders and other co-morbidities.

Evidence from research is harder to apply in these cases, so care plans should be developed on an individual basis, using formulation rather than diagnosis alone, to guide management.

Genetic and family studies suggest that particular personality patterns may predispose a person to develop an eating disorder, and that this may determine the nature of the eating disorder. It has been observed that there are two broad kinds of presentation. One group of patients seems to crave 'STABILITY'. They relieve anxiety, anger and guilt by means of avoidance and rituals of sameness, and often have obsessive compulsive symptoms. These tend to be patients with restrictive anorexia nervosa (AN). Where there is a co-existent PD, this is often obsessive compulsive PD.[74] Other patients' presentation is characterised by 'INSTABILITY'. They find themselves unable to tolerate feelings such as anxiety, boredom, anger and shame, and attempt to shift them by means of 'acting out' behaviours, risk-taking, self-harm and substance misuse. These patients form strong but insecure attachments to other people and use their disorder to communicate their perceived needs. These symptoms may be described as impulsive or borderline.

There is a risk that people with severe eating disorders (EDs) may be inappropriately diagnosed with co-morbid personality disorders, because some reversible aspects of their eating disorder can mimic the traits of personality disorders. For instance, a person with AN may resort to deliberate self-harm if their anorexia is 'taken away from them' by forcing them to eat. Such behaviour may now be more common because of the influence of social media.

It is crucial to be aware of the potential harmful effects of well-meaning treatment which can maintain or amplify personality difficulties, particularly during adolescence. The experience of life with a severe eating disorder – and perhaps spending formative years in hospital – may delay healthy psychosocial development. This may mimic or even cause lasting personality difficulties.

It is not always clear which is the primary problem for the patient – the PD or the ED – and which to treat first. It is important to take into account the effects of starvation and other ED behaviours on the brain. In patients who binge and purge, rapid swings in blood levels of glucose and of electrolytes act like drug highs and withdrawal. For underweight patients, therefore, even in the context of probable PD, refeeding is usually essential. Attention to nutrition and freedom from purging behaviours can make the brain and mind more responsive to psychotherapy, prescribed medication, and healthy psychosocial rewards.

For normal weight patients who have both EDs and PDs, the priority may be to address acquisition of life skills. Such patients should be offered treatment in the community where possible. It is interesting

that many therapeutic approaches to EDs have been borrowed or modified from treatments for PDs, so that choice of therapy is not necessarily a dilemma. The key skill to be learned in whatever therapy is chosen is emotion regulation. A recent meta-analysis[75] found that '…regardless of the intervention or disorder, both maladaptive emotion regulation strategy use and overall emotion dysregulation were found to significantly decrease following treatment… Parallel decreases were also found in symptoms of anxiety, depression, substance use, eating pathology and borderline personality disorder'.

Transitions between services are particularly perilous for patients with anorexia nervosa as well as for patients with PDs. Deaths from anorexia are highest in the transition between CAMHS and adult service, and suicides in the context of both EDs and PDs are more likely in the gaps between discharge from one service to another. The Royal College of Psychiatrists has recently issued guidance on the management of transitions for patients with EDs, which are even more relevant in the presence of PDs[76].

The management of EDs demands many of the same therapeutic skills required in the management of PDs; both conditions demand courage and support in managing high levels of physical risk, and even of death. The anxieties involved may be expressed as strong feelings by patients, carers and even colleagues. Healthy staff teams manage to work together to observe that such aggression is often a symptom rather than realistic feedback, whilst not dismissing elements of valid criticism. Staff need to be able to tolerate and understand temporary adoration or hatred without mirroring those behaviours back to patients or their families. Staff supervision, preferably including team supervision, is therefore essential.

Boundaries need to be firm but reasonable and should not be overturned without careful consideration. Attempts to work therapeutically with such patients depend crucially on development of a mutually respectful therapeutic relationship, although the patient may not be healthy enough to bring respect to the initial encounters.

Patients with PDs tend to seek help and care, even when this is maladaptive. In contrast, patients usually defend their ED weight-losing behaviours and keep them secret. Patients with both disorders may oscillate between desperately craving treatment and desperately resisting it in equal measure. Research has already demonstrated the very high burden on carers when a loved one has an ED.[77] Support for families and other carers can make a difference not only to patient outcomes but also to the wellbeing of carers. Joint work between professionals and carers can repair splitting, restore perspective and share skills.

Summary points

- Co-morbidity of PD and ED is extremely common.
- It is not always clear which is the primary problem, and the first to occur is not necessarily the priority for treatment.
- Where there is co-morbidity, individual formulation should guide treatment plans.
- The consequences of starvation, purging and other ED behaviours, may mimic symptoms of both ASD and BPD.
- For underweight patients, refeeding is a priority. This makes brain and mind more responsive.
- When a patient is at normal weight, there may be higher priorities than addressing the eating disorder. Emotional regulation skills as offered in several different therapy models help both ED and PD features.
- Transitions between services are particularly perilous for patients with anorexia nervosa as well as for patients with PDs. The combination may be lethal.
- The management of EDs demands many of the same therapeutic skills required in the management of PDs.
- Families and other lay carers should be included in care plans.

7. Training for staff on personality disorders

In England, the Knowledge and Understanding Framework (KUF) has been rolled out widely, with three levels of training:

- Personality Disorder Awareness and Train the Trainers
- BSc (Working with Personality Disorder: Developing Understanding and Effectiveness)
- MSc (Working with Personality Disorder: Extending Expertise, Enhancing Practice).

KUF awareness level training has been widely taken up and evaluated in England, however, this model of training has not been extended to Scotland, despite some discussion within the Scottish Personality Disorder Network.

In Scotland, there has been increasing interest and development of different training models for staff at all levels.

We have conducted a survey of trainings currently identified as relevant to personality disorder in Scotland. NHS Regional Boards in Scotland were surveyed with regard to training received or available in their area, to those working with people with personality disorder, which related to personality disorder. Respondents were also asked who this training was available to and whether there had been any evaluation of the training. No information has been received, as yet, from Borders, Fife, Orkney, Shetland, or Western Isles.

A summary of this is provided on the following page, with the full report available upon request.

Geographical area	Training and description
NHS Ayrshire & Arran	• Mentalization Based Therapy (MBT) training to community mental health treatment staff • Half-day or full-day awareness training on diagnosis in intellectual disabilities (for intellectual disability staff) • University of the West of Scotland – GradCert Personality Disorder • Making Positive Connections • Systems Training for Emotional Predictability and Problem Solving (STEPPS)
NHS Dumfries & Galloway	• Structured clinical management of personality disorder
NHS Forth Valley	• Safety and stabilisation training • MBT skills training
NHS Grampian	• MBT skills training • NHS Grampian In-patient Care Pathway • Working with Women Training • Robert Gordon University – Experiential learning personality disorders roleplay; Attachment Theory; Mentalization • Wot R U Like?
NHS Greater Glasgow & Clyde	• Basic personality disorder training for all Mental Health Staff • Education on development of Borderline Personality Disorder, relationships, definitions, stigma, treatments and tips for working with people with BPD – tailored to homeless population. • MBT skills training
NHS Highland	• Introduction to Personality Disorder full-day training • Personality Disorder Assessment, Formulation and Treatment Planning Full Day Training • Introduction to Personality Disorder eModule • Personality disorder Integrated Care Pathway • STEPPS
NHS Lanarkshire	• Dealing with people who are in distress
NHS Lothian	• Much more than a label – 2-day training course • Napier University, University of Edinburgh and Queen Margaret University – CAPS Personality Disorder Project • LEARN – Working with people with a diagnosis of Borderline Personality Disorder – 2-day training • Cognitive Analytic Therapy (CAT) Scotland – 2-year training to CAT practitioner level • NES – various training • British Isles Dialectical Behaviour Therapy Training
NHS Tayside	• NHS Tayside/Abertay University – The Science of Borderline Personality Disorder • Wot R U Like?

Training across all agencies

Most of the trainings listed on the previous page have been developed within health services, targeted at health staff. Some are more broadly aimed at staff working in other agencies who come into contact with people with a personality disorder diagnosis.

Criminal justice services, the Scottish Prison Service, Police Scotland, the Ambulance Services and Accident and Emergency staff and many third sector organisations would also be likely to benefit from basic training and understanding about personality disorder.

Recommendations

3. Adequate training, and supervision and opportunity for reflective practice should be provided for all staff working with people with personality disorder, as appropriate to their role.

4. All staff should strive to demonstrate the principles of compassion, curiosity and empathy when working with people with personality disorder and challenge stigma by promoting good attitudes towards people with personality disorder.

8. Developments in services for personality disorder

Provision of services for personality disorder across the UK is patchy, although there have been recent developments which aim to improve consistency and availability of services for personality disorder.

8.1 UK

The 2003 NIMHE document "Personality Disorder; no longer a diagnosis of exclusion"[1] reviewed care at that time in England (both specialist and general care) and set out aims to improve care. One of this document's stated aims was to ensure that people with PD, who experience significant distress or difficulty as a result of their disorder, are seen as being part of the legitimate business of mental health services. Findings at the time were that only 17% of trusts had any dedicated PD services, while 28% of trusts declared no identified service for people with this diagnosis. This reflected mixed views prevalent at the time amongst professionals, with scepticism about the availability of treatments, and little agreement about whether to cater for this group of patients at all. This was followed by the NIMHE document "The Personality Disorder Capabilities Framework"[78] which set out direction for the implementation of guidance, and development of services.

Progress was rapid, with development of four dangerous and severe personality disorder (DPSD) pilot sites, and 11 community projects and their evaluation, alongside development of the Knowledge and Understanding Framework (KUF); 'The key goal of the KUF is to improve service user experience through developing the capabilities, skills and knowledge of the multi-agency workforces in Health, Social Care and Criminal Justice who are dealing with the challenges of personality disorder.'

A follow-up survey was completed in 2014/2015[79], which aimed to reassess provision of PD services in England, and how these matched to the aspirations of the NIMHE documents from 2003.

Survey of services for people with personality disorder (England)

	2002	2015
Trusts with dedicated PD Services	**17%**	**84%**
Trusts with generic PD Services	**40%**	**91%**
Trusts with no service for individuals with PD diagnosis	**28%**	**0%**

This clearly demonstrates a positive change in the number of trusts providing some level of service for people with PD.

In January 2018, the charity MIND released "Shining lights in dark corners of people's lives: The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder." This consensus statement was agreed with other professional and third sector partners and advocates for improved treatment of those with personality disorders.[80]

8.2 Scotland

With permission from the authors of the 2014/15 survey of services for people with personality disorder in England, this group repeated the survey in Scotland, contacting all 14 health boards, plus identified private providers of services. There was a response rate of 10/14 trusts (73% of boards, representing approximately 80% of the population). A summary of results is available in **Appendix A**.

The survey found 73% of health boards in Scotland do not have a designated lead for PD.

Only two NHS health boards (Greater Glasgow and Clyde and Highland) reported having **specialist services** for PD. In addition to this, NHS Dumfries & Galloway have a dedicated consultation service, providing education, consultation and supervision.

Of the remaining health boards that do not have specialist services, the organisation of care for PD is through generic mental health services.

The main reasons cited for not having dedicated PD services are lack of funding, resources and organisational support.

Generic PD Services

Nine out of 11 health boards who responded provided data on generic mental health services for people with a diagnosis of personality disorder:

- 8/9 provide services that are not time-limited.
- 7/9 report no exclusion criteria for people to access services.
- All services provide medication management.
- 8/9 services provide monitoring of physical health care.
- All services report they provide psycho-education for patients and relatives.
- All services provide access to psychological therapy in the form of CBT.
- STEPPS, schema focussed therapy, MBT and DBT were available in some form in 40-50% of health boards who responded.

All services reported access to advocacy.

Recommendations

5. A managed clinical network for personality disorder should be established to co-ordinate development of equitable service provision across Scotland.

6. Health boards should include personality disorders in plans for mental health services.

7. People with personality disorder should expect equal access to and quality of service across geographical areas.

Integrated Care Pathways

Health boards were tasked by the Scottish Government through NHS QIS (Quality Improvement Scotland) to develop and implement care pathways for a number of mental disorders from 2008 onwards.[81] 'An Integrated Care Pathway (or ICP) is a person-centred and evidence-based framework. It tells multidisciplinary and multi-agency care providers, people using services, and their carers what to expect at any point along the journey of care. ICPs allow services to compare planned care with what was actually delivered. This information can be used to develop services and improve the patient journey.'

This has developed to different extents in different health boards. In some health boards, the presence of a PD clinical lead has helped to co-ordinate a clear vision and model of care, often around a clear theoretical psychological model of PD development and treatment.

In some of the larger health boards, this has proved more difficult. Possible factors in this might be the challenge of integrating different therapeutic models, often invested in by different professional groups, which might hinder development of a more coherent plan for service development.

Recommendation

8. There should be a personality disorder lead for each health board – to advocate for appropriate services and promote a consistent and evidence-based approach and continue the work which was commenced in developing Integrated Care Pathways (ICPs) within each health board.

Scottish Personality Disorder Network

In 2004, the Scottish Executive Mental Health Division commissioned the Centre for Change and Innovation (CCI) to undertake a review of the management and treatment of people with personality disorder in Scotland. This work commenced in November 2004 at a two-day meeting with a small multidisciplinary group producing a report, "Personality Disorder in Scotland: Demanding Patients or Deserving People?"[82]

The report was circulated widely for consultation, and on the basis of the 40 responses, strands of work were brought together and presented at a one-day conference in Glasgow in September 2005 under the title "Engaging with Personality Disorders".

On the recommendation of the consultation and final conference in September 2005, the Scottish Personality Disorder Network (SPDN) was commissioned and established, hosted by NHS Grampian.

Aims of the Scottish Personality Disorder Network:

- To meet at least three times a year in different locations around Scotland. This is to allow maximum accessibility for individuals to take part in the sharing and learning.

- To compose a Network database across Scotland of people from different professional backgrounds and users and carers that might help each other progress the work locally and nationally.

- To maintain a dedicated website which will share the work of the Network and provide information e.g., updated literature reviews, links to other relevant websites, updates on the English programme, a service user section, information on trainings available.

- To address the initial objectives, and other objectives which may emerge:
    1. Education and training
    2. Research
    3. Treatability and pathways of care
    4. Users and carers.

- To maintain contact with other relevant networks and organisations to share relevant information and learning.

- To submit reports to the Mental Health Division after each Network meeting as well as at the end of each year.

- To make contact with other relevant NHS bodies, in order to ensure partnership working and endorsement where appropriate.

- To feed into any relevant work being undertaken by the Scottish Executive Health Department that relates to this patient group, including policy creation.

The SPDN received further funding between 2006 and 2016, and continued to run well-attended events, open to all professional groups, service users and carers, and third sector agencies. There is currently interest in seeking further funding from the Scottish Government to continue the work of the SPDN.

Recommendation

9. Continue funding of the Scottish Personality Disorder Network, which has successfully acted as a broad-based learning network where good practice and innovation can be shared across Scotland.

This group would endorse the continuation of the SPDN, as an established broad-based organisation with a track record of sharing good practice and promoting developments in PD services across Scotland.

Themes from 2016 SPDN Round Table Discussions

The Royal College of Psychiatrists' working group on PD held an event in October 2016, in partnership with the SPDN in Glasgow. SPDN conferences are well attended, with wide representation from service user and carer populations, third sector agencies, and multiple professional groups including nursing, social work, medical, psychology and psychotherapy.

150 people attended on the day.

Box 5 summarises most popular responses from table discussions on the day.

Box 5: Most popular responses

In your experience of care for people with a diagnosis of PD, what has gone well?

- **Developing consistency of approach e.g. ICPs/ co-location of services/shared formulation**
- **Staff training**
- **Availability of psychological therapies**
- **Communication within and between services**
- **Giving clear diagnosis and developing treatment plan.**

In your experience of care for people with a diagnosis of PD, what has not gone well?

- **Inconsistent approach e.g. different teams with different approaches**
- **Not sharing diagnosis with patient**
- **Not enough specialist services/waiting times for specialist services/postcode lottery**
- **Lack of training for staff**
- **Stigma – different attitudes between staff groups**
- **Lack of resources.**

Suggestions for change?

- **Consistency across services/link up better with voluntary sector/social work**
- **Clear strategy and leadership**
- **Education for staff**
- **Education for patients**
- **Can condition be re-named and re-framed?/change perception of PD amongst general public, health services, including within psychiatry.**

Box 5: Most popular responses

What are the principles for providing better services?

- Consistency
- Communication between services
- Respect
- Training for staff
- Reflective practice
- Compassion
- Long term approach – accept slow pace of change
- Hope
- Challenge stigma/negative attitudes
- Patient involvement/inclusion.

What are the challenges of implementing change in services?

- Human politics: tensions between therapy modalities (e.g. DBT/MBT) and professional groups (psychology/psychiatry)
- Lack of resources
- Lack of time to implement good care
- Institutional and individual resistance to change
- Staff attitudes/stigma
- Lack of leadership/vision
- Difficulty implementing a general approach that all staff groups sign up to
- Lack of knowledge/education regarding PD.

People attending the conference were also invited to use three words they associate with personality disorder.
The results are captured in the wordcloud below:

9. Interfaces between mental health services and other agencies

9.1 Police

Police Scotland officers and staff come into contact with members of our communities on a daily basis who are in distress and/or experiencing a mental health related issue. The background to these calls can vary significantly, from officers coming across someone on the street or other public place in need of care, attention and treatment; someone calling 999 indicating their intention to harm themselves; or whilst dealing with a domestic incident or missing person enquiry, it becomes apparent that one of the parties involved is in distress or has a mental illness and that this has been a factor in the reason why the police have been called in the first place.

Mental health is perceived to account for an ever-increasing proportion of police time. It is important to remember that not all matters which are categorised as being associated with mental health actually equate to a clinical diagnosis

Demand

Crime figures are not an accurate measure of demand. Only one in five incidents attended by police results in a crime being recorded. Many of the time-consuming incidents relate to concerns for persons, missing/absconded persons and dealing with sudden deaths. The most common marker on the police's vulnerable persons database is mental health. As a result of attending various types of incidents last year, police recorded 57,000 mental health entries on the database.[83]

Community triage

There are now community triage (or similar) partnership arrangements between local NHS/mental health services and 11 local policing divisions across the country. These arrangements aim to provide an improved response to those individuals who call the police either in distress or suffering from a mental illness. The services range from telephone to face-to-face assessments and from out of hours/

weekend cover only to 24/7 telephony cover. Evaluation of some of the services have shown a large proportion of the demand where there is no immediate threat, risk or harm can be resolved with a telephone consultation followed up by referral to mainstream services the following day.

Training for Police Scotland

Police Scotland have just delivered a force-wide mental health awareness training programme to all police officers up to the rank of inspector (17,500 officers). The training was created in partnership with NHS Health Scotland, with approval from NHS Lanarkshire to use the MINDSET product.

10. Conclusions

Personality disorder is a complex and misunderstood mental disorder and, historically, the provision of services for those with a diagnosis of PD has been disparate across the UK and in Scotland. We have shown through various surveys of services and training in Scotland that care is not equal in all geographical regions. Personality disorder should be a priority for the Scottish Government, and specific actions should be included in the Mental Health Strategy to improve experience of care and outcomes for those with a diagnosis. There should also be a PD lead for each health board – to advocate for appropriate services

This report has also provided an outline of the controversies surrounding definition and diagnosis of PD, as well as a guide to best practice in managing PD. We hope this will improve understanding of PD and help those providing care to act with empathy, compassion and curiosity towards patients with personality disorder. Work which was commenced on the development of Integrated Care Pathways within each health board should be continued in some form, as consistency in approach has been identified by the SPDN as essential to a good experience of care. Complementary to this, the SPDN should continue to be funded to act as a broad-based learning network where good practice and innovation can be shared across Scotland.

11. Summary of recommendations

For these reasons, we make the following recommendations:

National

1. Personality disorder should be a priority for the Scottish Government, with inclusion of specific actions in the Mental Health Strategy relevant to improving experiences of care and outcomes.

5. A managed clinical network for personality disorder should be established to co-ordinate development of equitable service provision across Scotland.

8. There should be a personality disorder lead for each health board – to advocate for appropriate services and promote a consistent and evidence-based approach and continue the work which was commenced in developing Integrated Care Pathways (ICPs) within each health board.

9. Continue funding of the Scottish Personality Disorder Network, which has successfully acted as a broad-based learning network where good practice and innovation can be shared across Scotland.

Regional

6. Health boards should include personality disorders in plans for mental health services.

7. People with personality disorder should expect equal access to and quality of service across geographical areas.

Service level

2. Crisis plans for patients with personality disorder should be developed and shared between relevant service providers.

3. Adequate training, supervision and opportunity for reflective practice should be provided for all staff working with people with personality disorder, as appropriate to their role.

4. All staff should strive to demonstrate the principles of compassion, curiosity and empathy when working with people with personality disorder and challenge stigma by promoting good attitudes towards people with personality disorder.

Appendix

Appendix A – Scottish Personality Disorder Survey 2017

Scottish national survey of PD services 2017

Survey results were obtained for 10 out of the 14 health boards and the Ayr clinic. This is a response rate of 73%. The responses provide data for over 80% of the total population of Scotland.

Only two NHS health boards (Greater Glasgow and Clyde and Highland) reported having specialist services for personality disorder.

In addition to this, NHS Dumfries & Galloway have a dedicated consultation service, providing education, consultation and supervision.

Of the remaining health boards that do not have specialist services, the organisation of care for PD is through generic mental health services.

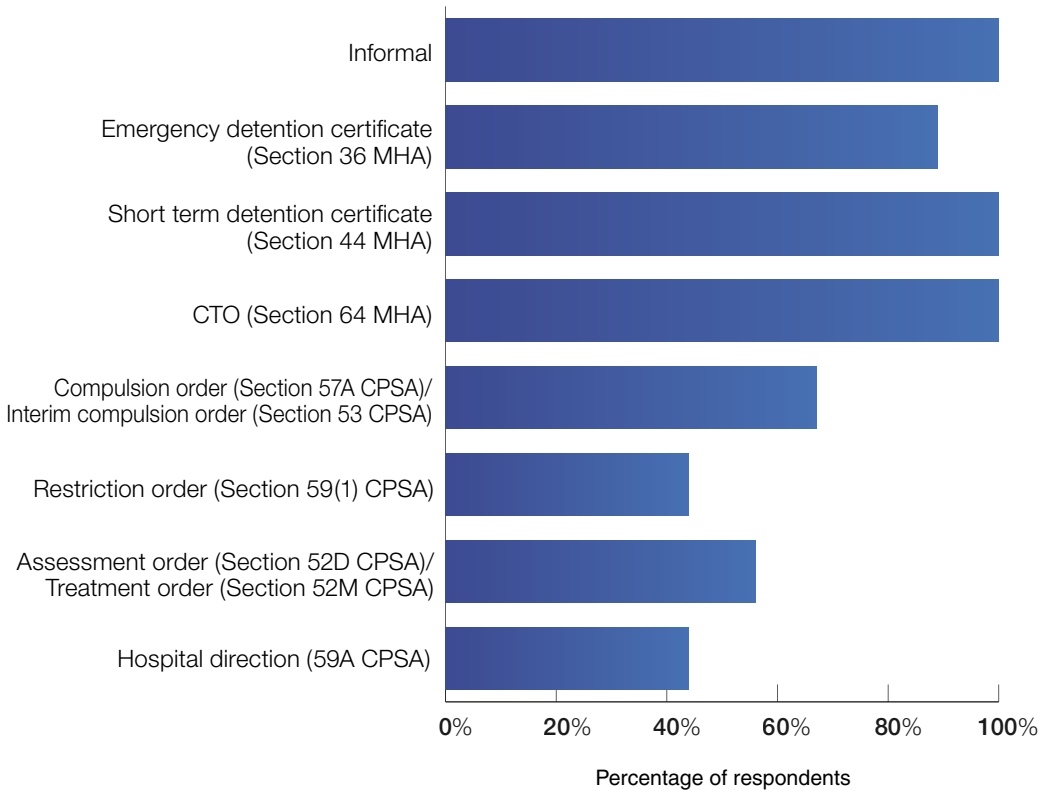
The main reasons cited for not having dedicated PD services are: lack of funding, resources and organisational support.

The majority of health boards (73%) do not have an identified lead for PD.

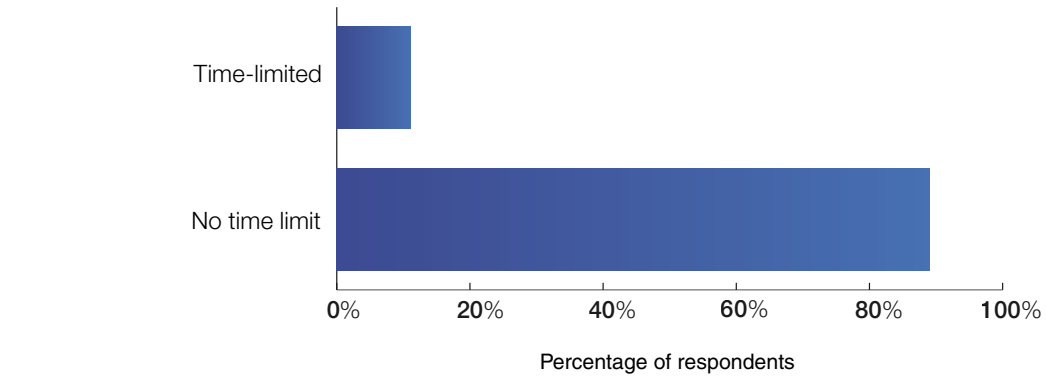
Generic PD services

Nine out of 11 health boards who responded provided data on GENERIC mental health services for people with a diagnosis of personality disorder.

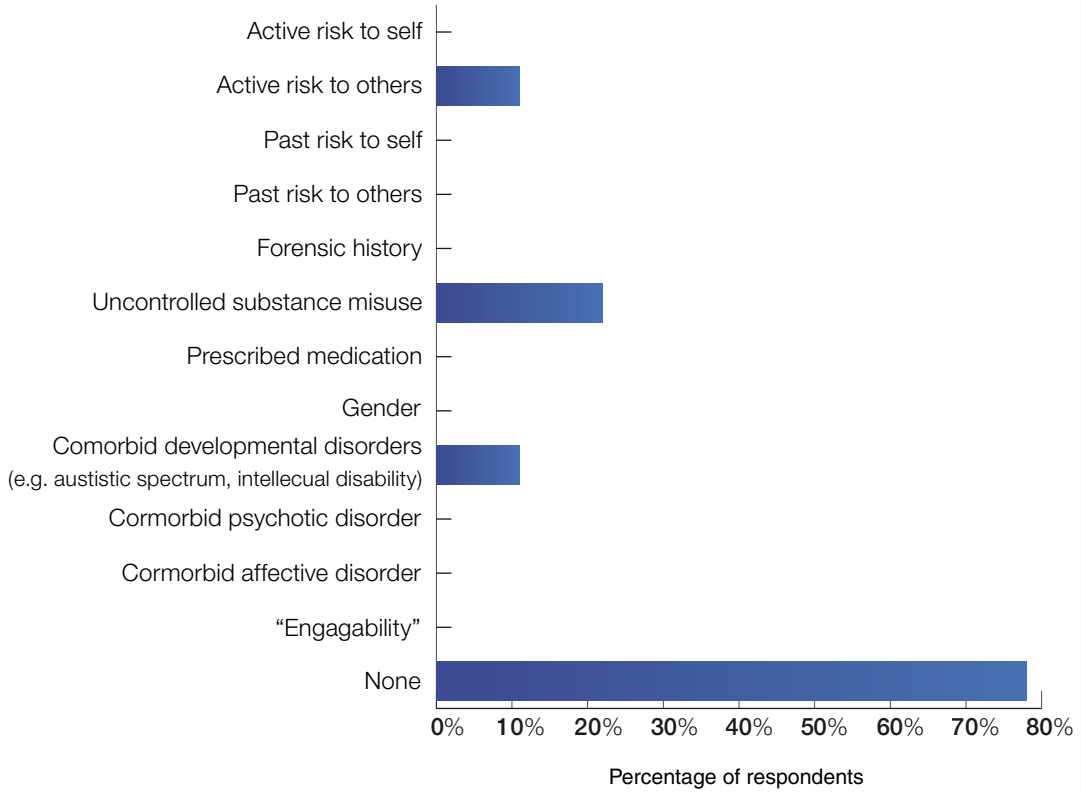
Q104: With respect to the Scottish Mental Health Act and Criminal Procedure (Scotland) Act 1995, please tick all the categories of service user managed by this service



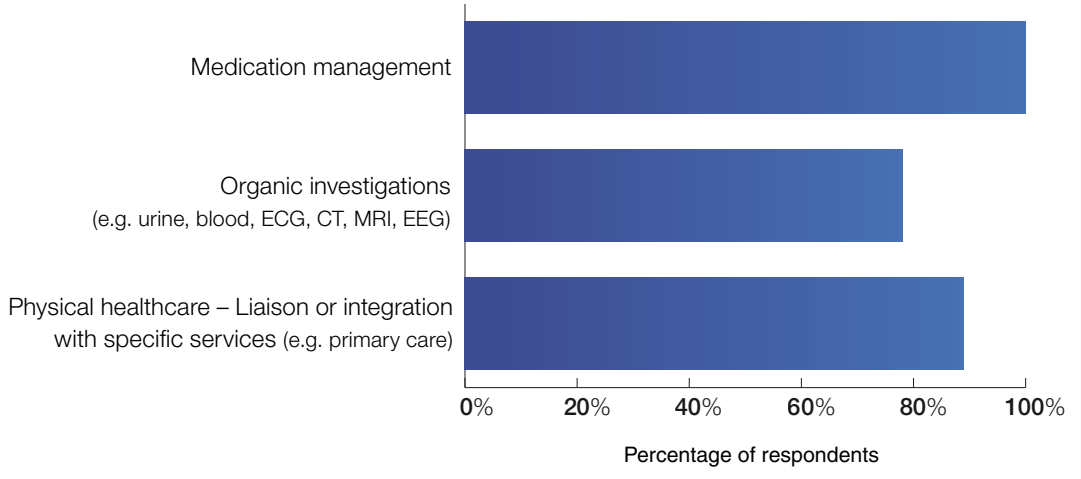
Q105: Is the service involvement time-limited?



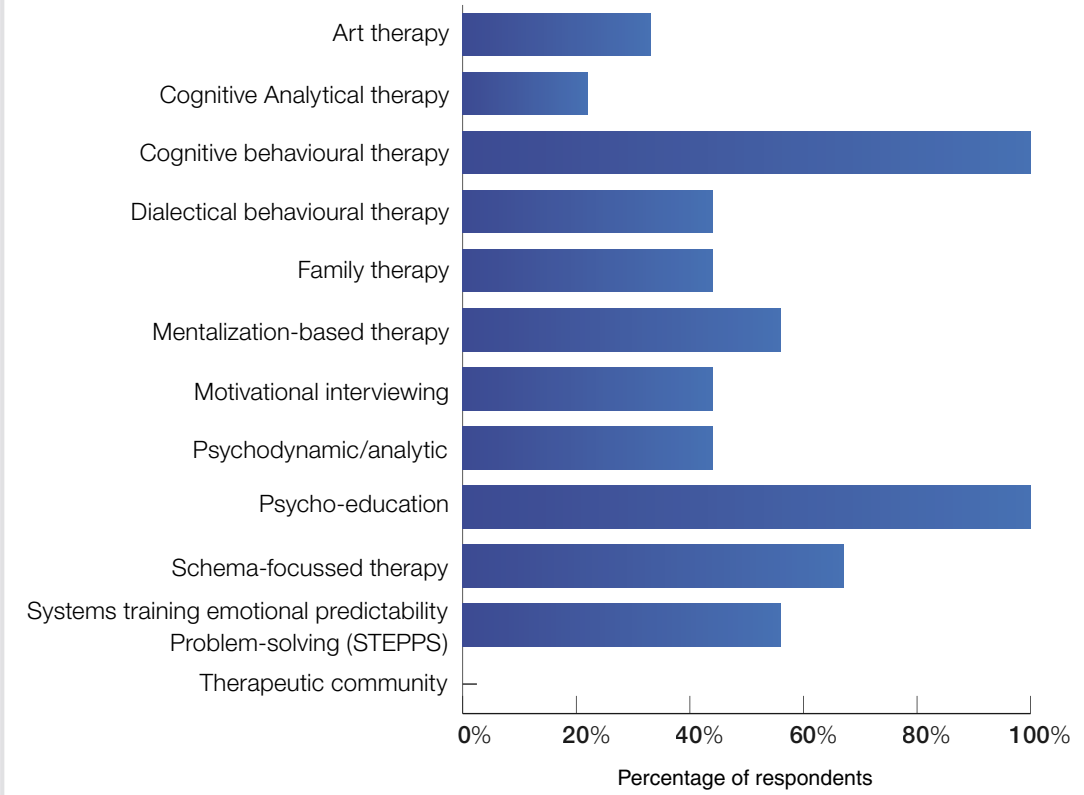
Q106: In this service, are any of the following exclusion criteria applicable?



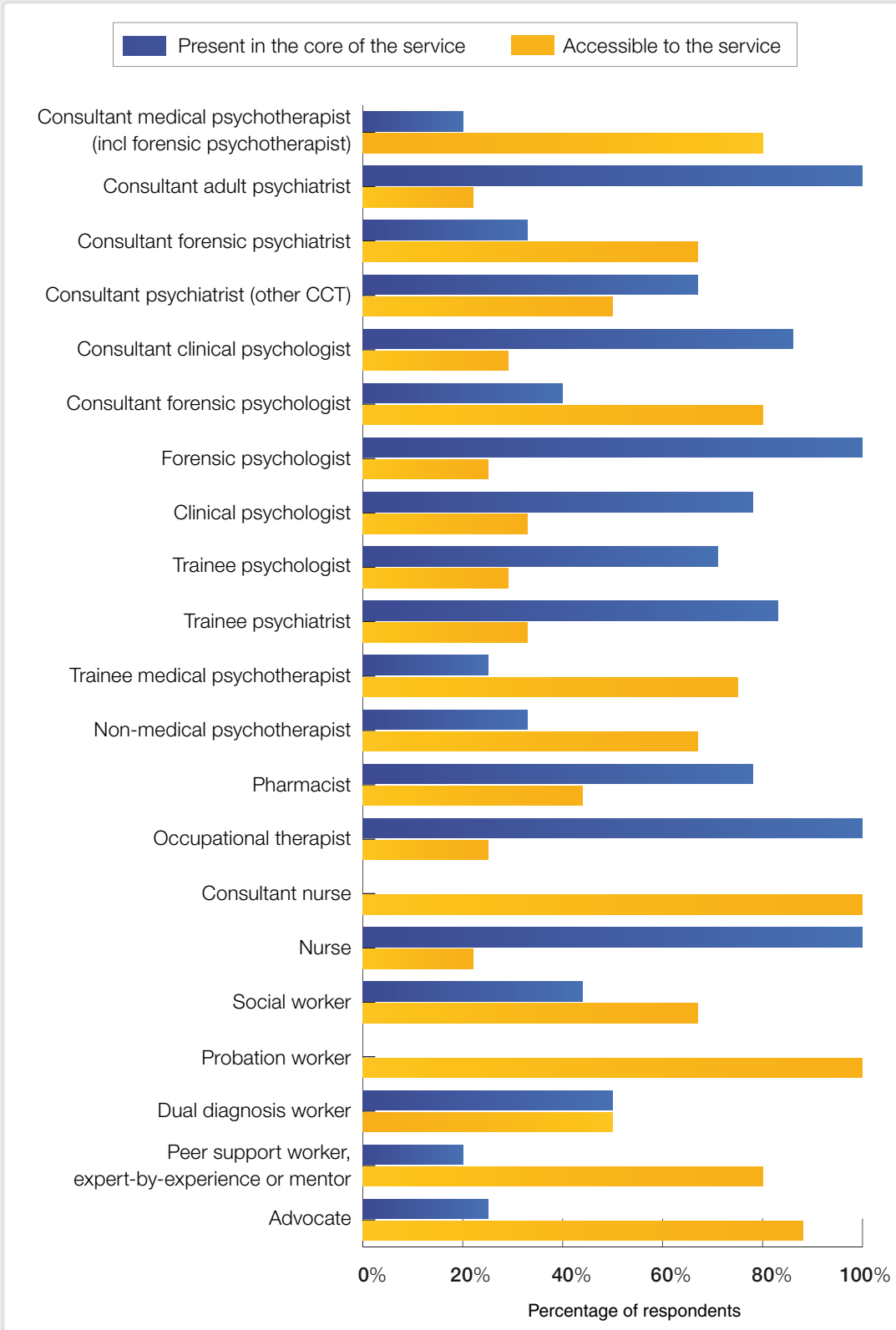
Q107: What biological interventions are offered in these generic services?



Q108: What psychological interventions are offered in this service?



Q110: Which professionals are present or accessible to this service?



Q 111-113

What level of PAID service user carer involvement is there with the service?

Only one service responded to this question, reporting service user/ carer involvement with:

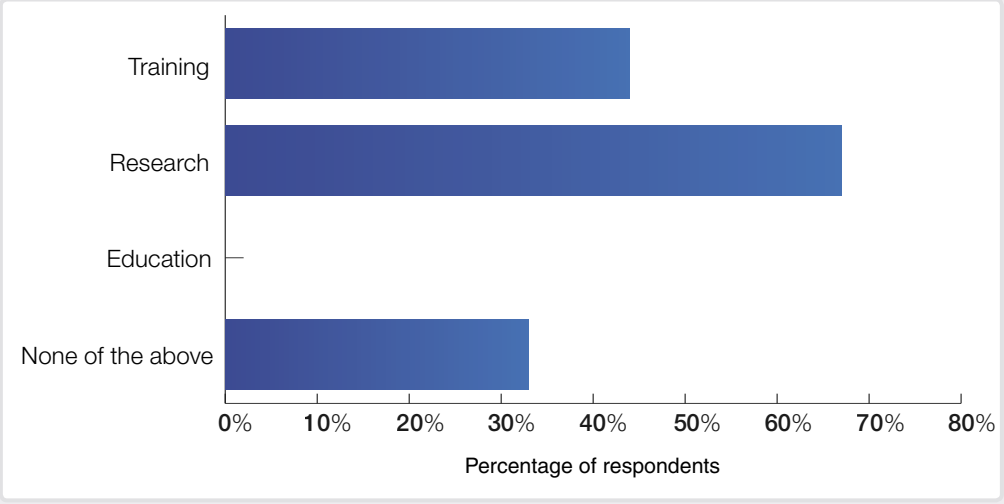
- Service development
- Joint care and risk planning
- Service delivery/peer support.

What level of VOLUNTARY (expenses only) service user and carer involvement is there within the service?

Only two services responded:

	Service user	Carer
Joint care and risk planning	**1**	**1**
Involved at service development level	**2**	**1**
Involved at service delivery level	**1**	**–**
Education and training	**–**	**–**
Co-delivery of treatment	**–**	**–**
Service leadership	**–**	**–**

Q114: Do these generic services actively engage in personality disorder-related activity?



Health boards with PD services:

NHS Greater Glasgow and Clyde

Name	Homeless PD Service	MBT for BPD	Pilot (time-limit) DBT
Tier	2, 3	2, 3	2, 3
Detained patients	Y	N	N
Time limited	N	18 month	12 month
Number referrals	60 per year	30 per year	38 per year
Caseload	60	30	38
Waiting list	N	4 month	1 month
Exclusion criteria	N	Y	Y
Biological interventions	Medication Physical health	N	N
Psychological interventions	MBT	MBT	DBT Psychoed STEPPS
Other service involvement	Training Education Research	Training Education Research	Training Education

NHS Highland:

Name	Assessment & Consultation Service	DBT	Coping & Succeeding Day Service	Education & Awareness Service
Tier	1,2,3	3	3	1,2,3
Detained Patients	Yes	No	No	NA
Time-limited	No	12 months	36 weeks	NA
No. of referrals	50 per year	8 per year	16 per year	300 per year
Caseload	10	8	8	NA
Waiting List	4 month	No	No	NA
Exclusion criteria	No	Yes	Yes	NA
Biological interventions	Medication rationalisation	No	No	NA
Psychological interventions	Formulation, Treatment recommendation	DBT DBT-PE	CBT DBT based skills	NA
Other Service Involvement	Training Education Research	Training Education	Training Education Research	Training Education Research

Discussion

The results demonstrate a disparity in provision of services available for personality disorder with only a minority of NHS health boards in Scotland providing specialist services.

This mapping exercise illustrates the need for further service development in the organisation of care and treatment for personality disorder.

References

1. NIMHE, Personality Disorder: No longer a diagnosis of exclusion, 2003.
2. Department of Health, ""Meeting the challenge/Making a difference" Practitioner Guide," 2014.
3. J. M. Stoffers, B. A. Vollm, G. Rucker, A. Timmer, N. Huband and K. Lieb, "Psychological therapies for people with borderline personality disorder." *Cochrane Database Systematic Review,* vol. 15 (8), 2012.
4. S. Gibbon, C. Duggan, J. Stoffers et al, "Psychological interventions for antisocial personality disorder," *Cochrane Database of Systematic Reviews,* vol. 16 (6), 2010.
5. I. A. C*ristea, C. Gentili, C. D. Cotet, D. Palomba, C. Barbui and P. Cuijpers, "Efficacy of Psychotherapies for Borderline Personality Disorder: A systematic Review and Meta-analysis," JAMA Psychiatry, vol. 74* (4), pp. 319-328, 2017.
6. Scottish Government, "Mental Health Strategy 2017-2027 - a 10 year vision," 2017.
7. World Health Organisation, ICD-10 Classification of Mental and Behavioural Disorders, 1992.
8. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, 2013.
9. J. Samuels, "Personality disorders: epidemiology and public health issues," *International Review of Psychiatry,* vol. 23 (3), pp. 223-233, 2011.
10. P. Tyrer, G. M. Reed and M. J. Crawford, "Classification, assessment, prevalence and effect of personality disorder," *Lancet, vol. 385* (9969), pp. 717-26, 2015.
11. H. Beckwith, P. F. Moran and J. Reilly, "Personality disorder prevalence in psychiatric outpatients: a systematic literature review," *Personal Mental Health,* vol. 8 (2), pp. 91-101, 2014.
12. P Morans, R Jenkins, A Tylee, R Blizard, A Mann, "The prevalence of personality disorder among UK primary care attender", *Acta Psychiatrica Scandinavica*, vol. 102 (s405), pp. 52-57, 2000.
13. P Tyrer, "Accurate recording of personality disorder in clinical practice", *BJPsych Bulletin*, vol. 42 (4), pp. 135-136, 2018.
14. J. M. Oldham, "Borderline personality disorder and suicidality," *American Journal of Psychiatry, v*ol. 163 (1), pp. 20-26, 2006.
15. P. Tyrer, H. Seivewright and T. Johnson, "The Nottingham study of neurotic disorder: predictors of 12-year outcome of dysthymic, panic and generalized anxiety disorder," *Psychological Medicine,* vol. 34 (8), pp. 1385-94, 2004.
16. P. Moran, E. Walsh, P. Tyrer, T. Burns, F. Creed and T. Fahy, "Does co-morbid personality disorder increase the risk of suicidal behaviour in psychosis?," *Acta Psychiactrica Scandinavica,* vol. 107 (6), pp. 441-8, 2003.
17. M. C. Fenton, K. Keyes, T. Geier, E. Greenstein, A. Skodol, B. Krueger et al, "Psychiatric comorbidity and the persistence of drug use disorders in the United States," *Addiction*, vol. 107 (3), pp. 599-609, 2012.
18. ML-Y Fok, RD Hayes, C-K Chang, R Stewart, FJ Callard, P Moran, "Life expectancy at birth and all-cause mortality among people with personality disorder", *Journal of Psychosomatic Research*, vol. 73 (2), pp.*104-7, 2012.*

19. H. B. Lee, O. J. Bienvenu, S. J. Cho, C. Ramsey, K. Bandeen-Roche, W. W. Eaton and G. Nestadt, "Personality disorders and traits as predictors of incident cardiovascular disease: Findings from the 23-year follow-up of the Baltimore ECA Study," *Psychosomatics,* vol. 51 (4), pp. 289-296, 2010.

20. J. Coid, M. Yang, P. Tyrer , A. Roberts and S. Ullrich, "Prevalence and correlates of personality disorder in Great Britain," *Br J Psychiatry,* vol. 188 (5), pp. 423-31, 2006.

21. M. P. Hengartner, M. Muller, S. Rodgers, W. Rossler and V. Ajdacic-Gross, "Interpersonal functioning deficits in association with DSM-IV personality disorder dimensions," *Social Psychiatry and Psychiatric Epidemiology,* vol. 49 (2), pp. 317-25, 2014.

22. A. E. Skodol, M. E. Pagano, D. S. Bender et al, "Stability of functional impairment in patients with schizotypal, borderline, avoidant or obsessive-compulsive personality disorder over 2 years," *Psychological Medicine,* vol. 35(3), pp. 443-451, 2005.

23. M. S. Soeteman, L. Hakkart-van Roijen, R. Verheul and J. J. V. Busschbach, "The economic burden of personality disorders in mental health care," *Journal of Clinical Psychiatry,* vol. 69 (2), pp. 256-265, 2008.

24. "'Personality Disorder' In the Bin," [Online]. Available: https://personalitydisorderinthebin.wordpress.com/

25. L. Johnstone, M. Boyle, J. Cromby , J. Dillon, D. Harper, P. Kinderman, E. Longden, D. Pilgrim and J. Read, The Power Threat Meaning Framework: Overview, Leicester: *British Psychological Society*, 2018.

26. V. J. Felitti, R. F. Anda, D. Nordenberg, D. F. Williamson, A. M. V. Spitz, M. P. Koss and J. S. Marks, "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study," *American Journal of Preventative Medicine,* vol. 14 (4), pp. 245-58, May 1998.

27. M. C. Zanarini, A. A. Williams, R. E. Lewis, R. B. Reich, S. C. Vera, M. F. Marino, A. Levin, L. Yong and F. R. Frankenburg, "Reported pathological childhood experiences associated with the development of borderline personality disorder," *American Journal of Psychiatry,* vol. 154(8), pp. 1101-6, 1997.

28. NHS Education for Scotland, "Transforming Psychological Trauma: A knowledge and skills framework for the Scottish Workforce," NHS Education for Scotland, 2017.

29. A. Somma, C. Sharp, S. Borroni and A. Fossati, "Borderline personality disorder features, emotion dysregulation and non-suicide self-injury: Preliminary findings in a sample of community-dwelling Italian adolescents," *Personality & Mental Health*, vol. 11 (1), pp. 23-32, 2017.

30. C. Sharp, C. Ha, J. Michonski, A. Venta and C. Carbone, "Borderline personality disorder in adolescents: evidence in support of the Childhood Interview for DSM-IV Borderline Personality Disorder in a sample of adolescent inpatients," *Comprehensive Psychiatry,* vol. 53 (6), pp. 765-74, 2012.

31. C. Sharp and S. Kim, "Recent advances in the developmental aspects of borderline personality disorder [Review]," Current Psychiatry Reports, vol. 17 (4), p. 556, 2015.

32. J. M. Guile and B. Greenfield, "Introduction personality disorders in childhood and adolescence," *The Canadian Child & Adolescent Psychiatry Review, v*ol. 13 (3), pp. 51-2, 2004.

33. P. M. Lewinsohn, P. Rohde, J. R. Seeley and D. N. Klein, "Axis II psychopathology as a function of Axis I disorders in childhood and adolescence," *Journal of the American Academy of Child & Adolescent Psychaitry,* vol. 36 (12), pp. 1752-9, 1997.

34. B. Greenfield, M. Henry, E. Lis, J. Slatkoff, J. M. Guile, G. Dougherty, X. Zhang, A. Raz, L. Eugene Arnold, L. Daniel, B. L. Mishara, R. K. Koenekoop and F. de Castro, "Correlates, stability and predictors of borderline personality disorder among previously suicidal youth," *European Child & Adolescent Psychiatry,* vol. 24 (4), pp. 397-406, 2015.

35. B. De Clerq, L. Verbeke, E. De Caluwe, T. Vercruysse and J. Hofmans, "Understanding adolescent personality pathology from growth trajectories of childhood oddity," *Development and Psychopathology, v*ol.29 (4), pp. 1403-1411, 2017.

36. E. Magallon-Neri, J. E. De la Fuente, G. Canalda, M. Forns, R. Garcia, E. Gonzalez, A. Lara and J. Castro-Fornieles, "Neither too much, nor too little. The dilemma of identifying personality disorders in adolescent patients with self-reports," *Psychiatry Research,* vol. 215 (3), pp. 683-6, 2014.

37. A. Chanen et al, "Early intervention for adolescents with borderline personality disorder: quasi-experimental comparison with treatment as usual," *Australian and New Zealand Journal of Psychiatry,* vol.43 (5), pp. 397-408, 2009.

38. M. C. Zanarini, F. R. Frankenburg, D. B. Reich and G. Fizmaurice, "Time to attainment of recovery from borderline personality disorder and stability of recovery: a 10 year prospective follow-up study," *American Journal of Psychiatry,* vol. 167(6), pp. 663-667, 2010.

39. A. W. Bateman and R. Krawitz, Borderline Personality Disorder: An evidence-based guide for generalist mental health professionals*, Oxford University Press, 2016.*

40. J. Livesley, Practical Management of Personality Disorder, Guilford, 2003.

41. A. Bartak et al, "Effectiveness of outpatient day hospital, and inpatient psychotherapeutic treatment for patients with cluster B personality Disorders," *Psychother Psychosom,* no. 80, pp. 28-38, 2011.

42. R. Borschmann, B. Barrett, J. M. Hellier, S. Byford, C. Henderson, D. Rose, M. Slade, K. Sutherby, G. Szmukler, G. Thornicroft, J. Hogg and P. Moran, "Joint crisis plans for people with borderline personality disorder: feasibility and outcomes in a randomised controlled trial," *British Journal of Psychiatry,* vol. 202 (5), pp. 357-64, 2013.

43. Scottish Government, "Distress Brief Interventions," [Online]. Available: http://www.dbi.scot/

44. D. Warrender, "Borderline personality disorder and the ethics of risk management: The action consequence model," *Nursing Ethics,* pp. 1-10, 2017.

45. National Institute for Health and Care Excellence (NICE) Guideline, "Borderline Personality Disorder: recognition and management. CG*78," 2009* (Reviewed 2015).

46. Australian Government National Health and Medical Research Council, "Clinical practice guideline for the management of borderline personality disorder," 2013.

47. Scottish Government, "The Matrix (2015) A Guide to Delivering Evidence-Based Psychological Therapies in Scotland," NHS Education for Scotland.

48. C. Paton, M. J. Crawford, S. F. Bhatti, M. X. Patel and T. R. Barnes, "The use of psychotropic medication in patients with emotionally unstable personality disorder under the care of UK mental health services," *Journal of Clinical Psychiatry,* vol. 76 (4), pp. 512-8, 2015.

49. J. Allen, P. Fonagy and A. Bateman , Mentalizing in Clinical Practice, *American Psychiatric Publishing,* 2008.

50. G. Newton-Howes, P. Tyrer and T. Johnson, "Personality disorder and the outcome of depression: meta-analysis of published studies," *British Journal of Psychiatry,* no. 188 (1), pp. 13-20, 2006.

51. R. Blackburn, C. Logan, J. Donnelly and R. Stanley, "Personality disorders, psychopathy and other mental disorders: co-morbidity among patients at English and Scottish high-security hospitals," *The Journal of Forensic Psychiatry & Psychology,* vol. 14 (1), pp. 111-137, 2003.

52. J. Warren, M. Burnette, S. South, P. Chauhan, R. Bale and R. Friend, "Personality disorders and violence among female prison inmates," *Journal of the American Academy of Psychiatry and the Law,* vol. 30 (4), pp. 502-9, 2002.

53. N. Singleton, H. Meltzer, R. Gatward , J. Coid and D. Deasey, Psychiatric morbidity among prisoners in England and Wales, London: *The Stationary Office, 1998.*

54. S. Fazel and J. Danesh, "Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys," *Lancet,* vol. 16:359(9306), pp. 545-50, 2002.

55. J. Coid, "Personality disorders in prisoners and their motivation for dangerous and disruptive behaviour," *Criminal Behaviour and Mental Health,* vol. 12 (3), pp. 209-26, 2002.

56. Coid, J, M. Yang, A. Roberts, S. Ullrich, P. Moran, P. Bebbington and N. Singleton, "Violence and psychiatric morbidity in a national household population - A report from the British Household Survey," *American Journal of Epidemiology,* vol. 164 (12), pp. 1199-1208, 2006.

57. J. Craissati, P. Minoudis, J. Shaw, S. J. Chuan, S. Simons and N. Joseph, Working with personality disordered offenders: A practitioner's guide*, Ministry of Justice Publications*, 2015.

58. K. Russell , Psychological Approaches to Personality Disorder in Forensic Mental Health Settings, The Forensic Network, 2016.

59. Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, "Drug misuse and dependence: UK guidelines on clinical management," London, 2017.

60. S. Fraiberg, Clinical studies in infant mental health: The first year of life, New York: Basic Books, 1980.

61. A. N. Schore, "The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology," *Development and Psychopathology,* vol. 8 (1), pp. 59-87, 1996.

62. S. Conroy, C. M. Pariante, M. N. Marks et al, "Maternal Psychopathology and Infant Development at 18 Months: The Impact of Maternal Personality Disorder and Depression," *Journal of the American Academy of Child & Adolescent Psychiatry,* vol. 51 (1), pp. 51-61, 2012.

63. J. Smith-Nielsen, A. Tharner, H. Steele, K. Cordes, H. Mehlhase and M. S. Vaever, "Postpartum depression and infant-mother attachment security at one-year: The impact of co-morbid maternal personality disorders," *Infant Behaviour & Development,* vol. 44, pp. 148-58, 2016.

64. R. A. Sansone and L. A. Sansone, "Borderline Personality in the Medical Setting," *The Primary Care Comparison for CNS Disorders,* vol. 17, no. 3, 2015.

65. V. Hong, "Borderline Personality Disorder in the Emergency Department: Good Psychiatric Management," *Harvard Review of Psychiatry,* vol. 24, no. 5, pp. 356-365, 2016.

66. R. Alexander and S. Cooray, "Diagnosis of personality disorders in learning disability," *British Journal of Psychiatry,* vol. 182, no. 44, pp. s28-s31, 2003.

67. R. T. Alexander et al, "Patients with personality disorders and intellectual disability – closer to personality disorders or intellectual disability? A three-way comparison," *The Journal of Forensic Psychiatry and Psychology,* vol. 23 (4), pp. 435-451, 2012.

68. Royal College of Psychiatrists, Diagnostic criteria for psychiatric disorders for use with adults with learning disabilities/mental retardation (DC-LD), London: Gaskell, 2001.

69. E. Zigler aet al, "Assessing Personality Traits of Individuals with Mental Retardation," *American Journal of Mental Retardation,* vol. 107 (3), pp. 181-193, 2002.

70. M. Mavromatis, "The diagnosis and treatment of borderline personality disorder in persons with developmental disability- 3 case reports," *Mental Health Aspects of Developmental Disabilities,* vol. 3 (3), pp. 89-97, 2000.

71. S. R. Wilson, "A four stage model for management of borderline personality disorder in people with mental retardation," *Mental Health Aspects of Developmental Disabilities,* vol. 4 (2), pp. 68-76, 2001.

72. J. Torr, "Personality disorder in intellectual disability," *Current Opinion in Psychiatry,* vol. 16 (5), pp. 517-521, 2003.

73. S. Reiss, Handbook of challenging behaviour: Mental health aspects of mental retardation, *Worthington OH: IDS Publishing,* 1994.

74. M. Martinussen, O. Friborg, P. Schmierer et al, "The comorbidity of personality disorders in eating disorders: a meta-analysis," *Eating and Weight Disorders*, vol. 22, no. 2, pp. 201-209, 2017.

75. E. Sloan, K. Hall, R. Moulding et al, "Emotion regulation as a transdiagnostic treatment construct across anxiety, depression, substance, eating and borderline disorders: A systematic review," *Clinical Psychology Review*, vol. 57, pp. 141-163, 2017.

76. Royal College of Psychiatrists, "CR208 Managing transitions when the patient has an eating disorder," 2017.

77. J. Whitney and J. Treasure, "Experiencing of caring for someone with anorexia nervosa: qualitative study," *British Journal of Psychiatry, vol. 187* (5), pp. 444-449, 2005. NIMHE, "Personality Disorders Capabilities Framework," 2003.

78. NIMHE, "Personality Disorders Capabilities Framework," 2003.

79. Dale O, Sethi F, Stanton C et al. Personality disorder services in England: findings from a national survey. *BJPsych Bulletin.* 2017;41(5):247-253. doi:10.1192/pb.bp.116.055251.

80. Mind et al, '"Shining lights in dark corners of people's lives": The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder,' 2018.

81. NHS Quality Improvement Scotland (QIS), "Standards for Integrated Care Pathways for Mental Health," NHS Quality Improvement Scotland (QIS), 2007.

82. Centre for Change and Innovation, "Personality Disorder in Scotland: Demanding patients or deserving people?," Scottish Executive, Edinburgh, 2005.

83. Police Scotland, "Policing 2026: Serving a Change in Scotland," 22 June 2017. [Online]. Available: http://www.scotland.police.uk/about-us/policing-2026

84. S. Fox and J. McFarlane, Stigma & Stones - living with a diagnosis of BPD.

List of contributors

We would like to thank the following organisations and individuals for their invaluable contribution to this report.

Working Group on Personality Disorder

The Royal College of Psychiatrists in Scotland:

Dr Amanda Cotton, Faculty of Perinatal Psychiatry

Dr Andrea Williams, Chair of the Short Life Working Group, Faculty of Medical Psychotherapy

Dr Anitha Gopala, Consultant Psychiatrist

Dr Darryl O'Brien, Consultant Psychiatrist

Dr Esther Mackenzie, Consultant Psychiatrist

Dr Ewen Douglas, Faculty of General Adult Psychiatry

Dr Helen Smith, Faculty of Child and Adolescent Psychiatry

Dr Jim Crabb, Faculty of General Adult Psychiatry

Dr Jon Patrick, Faculty of Forensic Psychiatry

Dr Lorna Harris, ST6 General Adult Psychiatry

Dr Lucie Colvin, Faculty of Medical Psychotherapy

Dr Michael Kehoe, Faculty of Addictions Psychiatry

Dr Tim Agnew, Consultant Psychiatrist

Dr Wojcik Wojtek, Faculty of Liaison Psychiatry

Dr Jane Morris, Faculty of Eating Disorders Psychiatry

Dr Elaine Lockhart, Faculty of Child and Adolescent Psychiatry

Dr Roch Cantwell, Faculty of Perinatal Psychiatry

Dr Tanya Thiagarajah, Faculty of Intellectual Disability Psychiatry

Alison Wren, British Association of Art Therapists

Dan Warrender, Lecturer in Mental Health Nursing, Robert Gordon University/ Honorary MBT Therapist, NHS Grampian

Clare Lamza, Nursing Officer, Mental Welfare Commission

Denise Keanie, Allied Health Professional

Dr Claire Maclean, Clinical Psychologist

Dr Katie Cathrow, GP

Dr Linda Treliving, Chair of the Scottish Personality Disorders Network

Fiona Gray, Peer Worker, Penumbra

Karen Campbell, Northern Community Justice Authority

Karen Lally

Rosie Wright, Police Scotland

Sally Fox

The Working Group would also like to thank the following individuals for their comments:

Dr Simon Stuart, Clinical Psychologist

Dr Emma Ducklin, Clinical Psychologist

Dr Alana Davis, Clinical Psychologist

Dr Sandra Fergusson, Consultant Clinical Psychologist

Dr Asleigh MacDougall, Clinical Psychologist

Dr Andy Summers, Consultant Clinical Psychologist

Alison McMullan, Consultant Clinical Psychologist