DRAFT FOR CONSULTATION
20 June – 19 August 2005

Forensic Mental Health Services Managed Care Network

Report of the Working Group on Services for People with Personality Disorder

27th May, 2005

CONTENTS

i ACKNOWLEDGEMENTS 3
ii EXECUTIVE SUMMARY 4

1. INTRODUCTION 14

2. BACKGROUND 16

3. CLASSIFICATION OF PERSONALITY DISORDERS 23

4. PREVALENCE OF PERSONALITY DISORDERS 27

5. ASSESSMENT OF PERSONALITY DISORDER INCLUDING RISK OF HARM TO OTHERS 29

6. TREATMENT AND MANAGEMENT OF PERSONALITY DISORDER 36

7. OVERVIEW OF SERVICES WITHIN THE SCOTTISH PRISON SERVICE 43

8. SPECIFIC CONSIDERATIONS 47

9. SURVEY OF SERVICES FOR PEOPLE WITH FORENSIC PERSONALITY DISORDER IN SCOTLAND 48

10. RESOURCES 58

11. PREVENTION 59

12. RECOMMENDATIONS 60

13. REFERENCES 66

14. APPENDICES 73
    14.1 Working Group Membership 73
    14.2 Services for people with personality disorders within the criminal justice system and forensic mental health care in England 74
    14.3 Survey of Services for People with Personality Disorder in Scotland 86
    14.4 Personality Disorder Case Vignettes 116

i. ACKNOWLEDGEMENTS

The group would like to thank the following individuals for their assistance in the preparation of this report.

Peter Bennett	Governor, HMP Grendon
James Carnie	Scottish Prison Service
Liz Cullen	The State Hospital
Vivienne Gration	The State Hospital
Julie Luther	Forensic Clinical Psychologist, DSPD Unit, HMP Durham
Sheila McLennan	Division of Psychiatry, The University of Edinburgh
Richard Shuker	Head of Psychology, HMP Grendon

ii. EXECUTIVE SUMMARY

This report was commissioned by the Forensic Mental Health Services Managed Care Network.

Terms of reference

- To consider the assessment and management of individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system;
- To describe services currently available in Scotland for this group;
- To describe treatment strategies currently used in Scotland with this group; and
- To make recommendations regarding the development of services and strategies, including staff training, for this group.

Terminology

Forensic personality disorder is the term used throughout the report to refer to individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system. It is essential to note that this term is used as an abbreviated description and is **not a diagnosis**.

Working methods

The group used recently published literature reviews, and presentations on or visits to relevant services as background information. A questionnaire was developed to gather information about existing services and treatment strategies for people who fall within the remit in Scotland.

Background Summary

- A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

- The assessment and management of people with personality disorder is an issue for mental health and social services as a whole, and is the subject of a recent discussion paper – Personality Disorder in Scotland: Demanding patients or deserving people? (Centre for Change and Innovation, 2005).

- Within the Mental Health (Care and Treatment) (Scotland) Act 2003 a mental disorder is defined as any mental illness, personality disorder or learning disability however caused or manifested. There are five criteria to be

considered in the use of the civil provisions of the Act for detention and/or treatment:

- Does the patient have a mental disorder?
- Does the patient have significantly impaired ability to make decisions about treatment?
- Does the patient present a significant risk to his/her health, safety or welfare; or the safety of others?
- Are treatments available that are likely to prevent the patient's mental disorder from worsening or alleviate its symptoms or effects?
- Is any order necessary?

Whilst the term personality disorder is specifically included in the 2003 Act most patients with this diagnosis will not come within its remit because they will not have significantly impaired ability to make decisions about treatment. This criterion is excluded under the provisions for mentally disordered offenders although the other four criteria remain in place. Issues of treatability will therefore be prominent in any decision to use the 2003 Act for mentally disordered offenders with a primary diagnosis of personality disorder.

- Personality disorders are common:

  - 6-15% of the general population
  - 60-80% of male prisoners (50% female prisoners).
  - 5% of the State Hospital population **-** primary diagnosis of antisocial personality disorder
  - 27-42% of the State Hospital population **-** secondary diagnosis of antisocial personality disorder

- There is evidence to suggest that services fail to record or diagnose personality disorder in the inpatient population. Only 5.1% of discharges from psychiatric hospital in Scotland in 2000 were given a primary or secondary diagnosis of personality disorder even though over one-third of patients in psychiatric hospital would be expected to have a diagnosis of personality disorder.

- At the present time it is routine psychiatric practice in Scotland **not** to admit individuals with a primary diagnosis of personality disorder to forensic psychiatric units.

- Community forensic mental health service provision in many parts of Scotland is rudimentary. Most forensic psychiatrists do have a small cohort of outpatients with a primary diagnosis of personality disorder.

- The majority of individuals with a primary diagnosis of personality disorder who offend in a manner that merits a custodial disposal will be sent to prison or to a young offenders' institution.

  - The Scottish Prison Service strategy for the management of prisoners is based on the identification of problem behaviours and needs. It does not focus its management of prisoners on the concept of personality disorder,

nor is the majority of its staff qualified to assess and diagnose this condition.
  - There are three principal structures that allow for the identification and management of prisoners with behavioural problems and needs: Sentence Management, Risk Management groups and Mental Health teams. The focus of the latter is mainly on people suffering major mental illness rather than personality disorder.
  - A variety of cognitive behavioural therapy based interventions with a focus on violent behaviour and sexual offending behaviour are delivered by prison staff, including officers, psychologists and social workers.

- The report on Serious, Violent and Sexual Offenders (Scottish Executive, 2001) recommended the creation of the Risk Management Authority, the Risk Assessment Order and the Order for Lifelong Restriction as methods of controlling future risk. These orders commence in early 2006. The emphasis of the report is on offence and risk, rather than on a diagnosis such as psychopathy or severe personality disorder. This is a markedly different approach from that being developed in England and Wales, where specific units for people with dangerous and severe personality disorder have been established.

- There has been considerable development of services for the assessment and treatment of people with personality disorder in recent years in England and Wales, and in the creation of a structure to encourage this. These include:

  - Rejection of personality disorder as a diagnosis of exclusion
  - The creation of the Multiagency Public Protection Arrangements which require police, probation and prison officers to work together to manage the risks posed by dangerous offenders in the community, including a statutory duty for health, housing, social services, education, social security and employment services, youth offending teams and electronic monitoring providers to cooperate with area Multiagency Public Protection Panels (MAPPPs). MAPPPS have four core functions:
    - i. Identification of MAPPA offenders
    - ii. Sharing of relevant information
    - iii. Assessment of risk of serious harm
    - iv. Management of risk of serious harm
  - Investment by the Department of Health and the Home Office in establishing pilot services for people with personality disorder in general psychiatric and forensic services including pilot community forensic personality disorder services and five inpatient forensic personality disorder units.
  - The development of the concept of Dangerous and Severe Personality Disorder (DSPD) and the creation of four DSPD units: 2 in prison and 2 in high security hospitals.
  - The continued role of HMP Grendon, and other units, as therapeutic communities for prisoners with challenging behaviours.

Survey of Services for People with Forensic Personality Disorder in Scotland

- A survey of current services available, and treatment strategies in use, in Scotland for individuals with a forensic personality disorder was carried out. The questionnaire was sent to the lead psychiatrist for each of the forensic services in Scotland (10/11 received). In addition, the survey was sent to members of the Scottish Forensic Clinical Psychologists' Interest Group (5/15 received) and to directors of social work and chief social work officers throughout Scotland (11/46 received).

  The main findings of the ten forensic psychiatric services that responded were:

- 7 implicitly exclude people with a primary diagnosis of personality disorder from admission.
- 7 assess people with a primary diagnosis of personality disorder.
- 8 use multidisciplinary and 10 comprehensive methods of assessment but only 4 use structured clinical tools for the assessment of personality disorder.
- 6 services did not accept people with a primary diagnosis of personality disorder for specific intervention, treatment or management, and 4 serivces did not accept people with a secondary diagnosis.
- No reliable figures on the assessment or management of people with a primary or secondary diagnosis of personality disorder could be supplied. Those that were supplied suggest major unmet need when compared to known prevalence figures.
- Access to services appropriate to people with personality disorder was variable:

Drug and alcohol services	10
Cognitive behavioural therapy	9
Individual psychotherapy	6
Dialectical behaviour therapy	2
Specialist interventions	4

  (such as relapse prevention, sex offending, problem-solving)
- Training requirements were identified in particular for developing case formulations and employing evidence based interventions.

Recommendations

General

1. Personality Disorder should not be a diagnosis of exclusion from forensic mental health services in Scotland. Forensic Mental Health Services should develop a philosophy of care or stated service principles for people with forensic personality disorder.

2. Services for people with personality disorders are required given the frequency with which they are found in the criminal justice and mental health systems in Scotland.

3. The Forensic Network should track any proposals arising from the work of the Centre for Change and Innovation and the Scottish Executive in the assessment

and management of people with personality disorder in other fields of mental health throughout Scotland.

4. Data collection systems should be improved to provide accurate information on forensic personality disorder for service planning.

Assessment of People with Personality Disorder

The following practice is recommended for the assessment of people with a suspected personality disorder. It is recognized that the ideal standard will not be attainable at all consultations and will require modification accordingly. It should be attainable in all forensic mental health inpatient settings.

5. A diagnosis of personality disorder (primary or secondary) should be considered during all forensic mental health consultations.

6. The assessment of personality disorder should ideally be multidisciplinary and include:

   - an emphasis on third party information
   - assessment for the presence of axis I disorders
   - use of standardized measures of personality disorder
   - assessment of risk of harm to others using standardized measures
   - a formulation of symptoms and behaviours associated with the personality disorder

7. Suggested assessment measures include:

   - Personality Disorder - Clinical assessment based on ICD-10 or DSM-IV criteria
     - International Personality Disorder Examination
     - Psychopathy Checklist-Revised or Screening Version
   - Mental Illness - Clinical ICD-10
   - Risk of Violence - Historical Clinical Risk 20
   - Risk of Sexual Offending - Risk of Sexual Violence Protocol; Risk Matrix 2000

Management of People Personality Disorder

8. The evidence base for the treatment of personality disorder is not strong. There is some evidence of the efficacy of structured coherent psychological approaches for people with personality disorder but the use of these and of medication for the treatment of specific symptoms is under researched. In addition, such approaches require further assessment of their effectiveness in people with a forensic personality disorder.

9. Any interventions should be developed in line with the evidence based ten Home Office accreditation criteria for offending behaviour programmes and should:

    - have a clear model of change (i.e. a theoretical underpinning to the programme, based on a model of personality development and disorder)
    - have a clear criteria for patient selection
    - target relevant dynamic risk factors
    - use effective methods
    - teach skills that will assist patients to avoid offending and pursue legitimate pursuits
    - have a clear description of the sequencing, intensity and duration of the different components of the programme
    - maximise engagement and motivation
    - ensure continuity with other programmes/services
    - monitor its performance
    - undertake a long term-evaluation

10. Services developed for people with personality disorders should adopt a problem behaviour focus arising from a case formulation and address a range of interventions that target the factors that underlie risk related behaviour.

11. These services require to be developed within a range of environments including the community, hospital and prison.

Community

12. The Risk Management Authority should be given the powers to develop arrangements similar to those provided by Multi Agency Public Protection Panels in England and Wales to encourage the involvement of health and social services staff in the assessment and management of individuals with forensic personality disorder in the community by the development of a system of information sharing, responsibility sharing, risk assessment and risk management. To successfully engage staff in working with people with forensic personality disorder, and thereby increase the likelihood of improved public safety, it is essential that a culture of information exchange and shared responsibility is developed, and that a blame culture is avoided.

13. A formal system for criminal justice social workers to request forensic mental health assessments should be established. This should be offered as a pilot service in one or more area to assess workload and resource requirements. These pilots should develop clear referral criteria and an assessment battery. Such criteria are likely to focus on problem behaviours rather than a specific diagnosis. Additional resources will be required for the pilots. Any pilot must be evaluated. The pilots should offer an assessment service with treatment as usual, and any specific collective treatment and / or training needs should be identified during the pilot for further service planning.

14. The Forensic Network should monitor the outcome of the pilot community services currently being established in England and Wales.

Inpatient Services

15. Patients with a primary diagnosis of personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system, are not normally admitted on a compulsory basis to psychiatric hospital. At present no change is recommended to current clinical practice in Scotland.

16. The Forensic Network should monitor the outcome of the pilot inpatient services for people with a personality disorder and DSPD units currently being established in England and Wales before considering any change to current clinical practice. Any future developments of inpatient units for people with a primary diagnosis of personality disorder in Scotland must include clearly defined routes to lower security and to the community.

17. Recognition should be given to the problem of personality disorder as a co-morbid diagnosis, and assessment and management protocols made available in all forensic mental health settings accordingly.

18. It is recognised that there is a small cohort of patients in special security psychiatric care in Scotland that have a primary diagnosis of personality disorder. Whilst some of these cases are historical there is evidence to suggest that there may be a small number of patients added to this cohort because of a change in diagnosis. The following are therefore advised to avoid further cases:

    - A recommendation of an interim hospital order or interim compulsion order to court as standard practice to prolong the period of assessment.
    - A recommendation of a hospital direction to court in cases where personality disorder may be the prominent issue in future risk to public safety and the link between the major mental illness / learning disability and the offending behaviour is not clear.
    - An automatic review of all patients detained under a transfer direction or transfer for treatment direction in forensic mental health inpatient units before being considered for ongoing civil detention after the expiry of their prison sentence. Local arrangements should be put in place for such reviews.
    - The development of similar options for the courts in Northern Ireland.

19. A service should continue to be developed for the small group of patients with a primary diagnosis of personality disorder currently in the State Hospital whose discharge is prevented under the provisions of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 .

20. The rehabilitation of these patients outwith the State Hospital is problematic. The development of a specialist team (psychiatry, psychology, nursing, social

work, occupational therapy) for the resettlement of patients with a primary diagnosis of personality disorder outwith the State Hospital should be considered to provide outreach support to and shared clinical responsibility with the local team in an inpatient or outpatient setting. In combination with the MAPPA style arrangements proposed (12) this may encourage local teams to engage with these patients. These arrangements involve police, criminal justice social workers, prison officers, health professionals and staff from a wide variety of social services in the identification, assessment and management of people with forensic personality disorder.

21. The Forensic Network should ask the Scottish Executive for a view on the referral of cases to the Scottish Criminal Cases Review Commission, where the Responsible Medical Officer considers that the primary diagnosis is one of personality disorder but evidence was given in court at the time of the trial and / or disposal regarding a primary diagnosis of a different mental disorder

Prison

22. The group supported the focus of the Scottish Prison Service during the initial sentence management process on identifying problems and needs rather than diagnosis. There is a comprehensive assessment process for identifying risk and needs and there is a structure in place to deal with those identified as high risk or problematic through the Risk Management Groups.

23. The group recognised that the issue of personality disorder is central to many problem behaviours found in prisons, to failure to engage with therapeutic programmes and to an excessive drain on health service resources within prison by continual demands for assessment and medication. The group therefore recommended that in these contexts assessment of individuals for the presence of personality disorder would assist in their subsequent management.

24. The group identified a need to strengthen mental health teams within prisons. All prisons should have a multidisciplinary health team of a standard set out in the policy document "Positive Mental Health" (Scottish Prison Service, 2002). At the present time these are focussed entirely on the identification and treatment of those with mental illness, and struggle to fulfil this role. In addition, they are rarely truly multidisciplinary.

25. The group identified a need for visiting mental health professionals to engage more widely with the therapeutic work of the prison service, including offender based programmes.

26. One or more pilot prison and mental health team should be identified to carry out detailed assessments of problematic prisoners, and to develop management plans in conjunction with the prison's Risk Management Group. These pilots should develop clear referral criteria, an assessment battery, and an agreed management strategy tailored to each individual. Additional resources will be required. Any pilot must be evaluated.

27. Staff training and supervision will be required to work with people with personality disorder in prison. This will be required on two levels: firstly, for staff to assess and manage these individuals; and secondly, for staff carrying out specific programmes which may contain these individuals within the prison.

28. There is evidence from HMP Grendon that prisons or special units run on the principles of a therapeutic community can improve aggressive behaviour within that setting. It is recognised that these units require strong leadership and a clear psychotherapeutic principle basis to succeed and that focus may be lost over time. The group recommends that the Forensic Network examines the evidence, as it becomes available, from the DSPD units in England and findings from the Scottish prison pilot recommended above (26) before making any recommendation on re-establishing such units within the Scottish Prison Service.

29. The Group acknowledged the day programme approach developed in HMP Barlinnie (Open Doors Programme) and HMP Perth for vulnerable prisoners or prisoners with major mental illness. To succeed, any such day programmes must have a defined client group and therapeutic focus, and access to multidisciplinary input. The group recommends that the Forensic Network examines the evidence, as it becomes available, from the Scottish prison pilot recommended above (26) before making any recommendation on establishing day programmes for people with personality disorder within the Scottish Prison Service.

Training and Supervision

30. Training and supervision will be essential in any setting for the successful engagement of staff with individuals with personality disorder. This will require:

    - A change of culture
    - The development of a competency framework for practice
    - The development and use of robust risk management procedures

    Specific training programmes should be created for the pilots recommended above (13 and 26) and at the State Hospital (18-21). The training programmes should subsequently be rolled out to all forensic mental health settings in Scotland.

31. All individuals acting as key workers or carrying out interventions with people who have a personality disorder should receive 1 hour of clinical supervision per week, from a suitably experienced professional.

Specific Considerations

32. The Forensic Network should ask the chairs and nominated members of the working groups on women and learning disability to consider the particular issue of personality disorder for their respective cohorts in light of the recommendations contained in this report.

Resources

33. The development of services for the assessment and management of individuals with forensic personality disorder will require resources. The various recommendations, if accepted, will require implementation plans including detailed financial plans.

Prevention

34. Adult forensic mental health services should make their expertise in the causation, assessment and management of personality disorder readily available to child and adolescent psychiatric services, social services and youth criminal justice services, to assist in the development of programmes designed to prevent the development of antisocial personality disorder.

35. The Forensic Network should, in conjunction with appropriate child and adolescent psychiatric services, develop forensic child and adolescent forensic mental health services.

1. INTRODUCTION

1.1 Background to the report

This report was commissioned by the Forensic Mental Health Services Managed Care Network. Membership of the Committee is listed in Appendix A.

1.2 Terms of reference

- To consider the assessment and management of individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system;
- To describe services currently available in Scotland for this group;
- To describe treatment strategies currently used in Scotland with this group; and
- To make recommendations regarding the development of services and strategies, including staff training, for this group.

1.3 Terminology

Forensic personality disorder is the term used throughout the report to refer to individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system. It is essential to note that this term is used as an abbreviated description and is **not a diagnosis**.

1.4 Working Methods

The group initially met in June 2004 and held 8 meetings in total. Group members received formal presentations from, or at, the sources set out in table 1.

Table 1 Presentations

Date	Topic	Presenter(s)
July 2004	In patient and community services for personality disordered individuals in England	Prof. Don Grubin
July 2004	Dangerous and Severe Personality Disorder Units	Ms. Julie Lowther
August 2004	Assessment and Treatment of individuals with personality disorders – a review of the literature	Dr. Edward AS Duncan
September 2004	Risk Management and Personality Disorders in the Scottish Prison Service	Prof. Roisin Hall and Ms Diane Perera
November 2004	Managing Personality Disorder in NHS Scotland: Conference	Centre for Change and Innovation
December 2004	Visit to HMP Grendon – therapeutic community	Peter Bennett, Governor Richard Shuker, Head of Psychology

A systematic review of the literature was not commissioned. The group made use of recently published literature reviews, the presentations and the knowledge of its members.

1.5 Questionnaire

A questionnaire was developed to gather information about existing services and treatment strategies for people with personality disorder in Scotland.

1.6 Vignettes

The report contains vignettes in appendix D to illustrate the problems and behaviours commonly found in people with forensic personality disorder.

2. BACKGROUND

2.1 Current Clinical Practice

At the present time it is routine psychiatric practice in Scotland **not** to admit on a compulsory basis, individuals with a primary diagnosis of a personality disorder to forensic psychiatric units.

There has been a decline in the detention of people in secure psychiatric care with a primary diagnosis of personality disorder since the second world war but the escape from the State Hospital and triple homicide by two individuals with a primary diagnosis of personality disorder in 1976 had a significant impact on the development of current working practice and contributed to a major reduction in the numbers detained with a primary diagnosis of personality disorder in special security in Scotland (Darjee and Crichton, 2003).

Currently, there are only a small number of patients detained in the State Hospital with a primary diagnosis of personality disorder. Most are longstanding patients who have frequently had a change of diagnosis since admission. Challenges surrounding their detention have continued to arise. In particular, the unconditional discharge of one restricted patient by a Sheriff Court in 1999 on the grounds that he was untreatable although he had a mental disorder, resulted in the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. It changed the legislative definition of mental illness to include “personality disorder” and added a criterion of serious risk to others so that untreatable restricted patients with a mental disorder could continue to be detained.

Community forensic mental health provision in many parts of Scotland is rudimentary. Most forensic psychiatrists do have a small cohort of out-patients with a primary diagnosis of personality disorder.

The majority of individuals with a primary diagnosis of personality disorder who offend in a manner that merits a custodial disposal will be sent to prison or to a young offenders’ institution. The focus of mental health services in prison is currently on psychotic disorders or other mental illness, rather than personality disorder.

2.2 Mental Health Legislation

The Mental Health (Scotland) Act 1984 allows the detention of people with a primary diagnosis of personality disorder although the term psychopathic disorder is not used. An individual can be detained in hospital under the 1984 Act if:

- s/he is suffering from a mental disorder of a nature or degree which makes it appropriate to receive medical treatment in hospital; and
- *In the case where the mental disorder is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct* (some forms of personality disorder), such treatment is likely to alleviate or prevent a deterioration; and

- It is necessary for the health or safety of that person or for the protection of other persons that such treatment should be received and it cannot be provided unless s/he is detained in hospital.

People with a primary diagnosis of personality disorder may fail the appropriateness test and / or the treatability test.

The Mental Health (Care and Treatment) (Scotland) Act 2003 will be implemented in October 2005. Within the 2003 Act, mental disorder is defined as any mental illness, personality disorder or learning disability however caused or manifested. A person is not considered to be mentally disordered by reason *only* of any of the following-

- Sexual orientation
- Sexual deviancy
- Transsexualism
- Transvestism
- Dependence on, or use of, alcohol or drugs
- Behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person
- Acting as no prudent person would act.

Under the new Act, personality disorder is formally recognised. The underlying principles of the Act must be considered even when the provisions of the Act are not utilised and all patients have the right to request an assessment of needs for health services and /or community care.

There are 5 criteria to be considered in the use of the **civil** provisions of the Act for detention and / or treatment:

- Does the patient have a mental disorder?
- Does the patient have significantly impaired ability to make decisions about treatment?
- Does the patient present a significant risk to his/her health, safety or welfare; or the safety of others?
- Are treatments available that are likely to prevent the patient's mental disorder from worsening or alleviate its symptoms or effects?
- Is any order necessary?

Whilst the term personality disorder is specifically included in the 2003 Act, most patients with a diagnosis of personality disorder will not come within its remit because they will not have significantly impaired ability to make decisions about treatment. This criterion is excluded under the provisions for mentally disordered offenders although the other 4 criteria apply. Issues of treatability will therefore be prominent in any decision to use the 2003 Act for a mentally disordered offender with a primary diagnosis of personality disorder.

2.3 Scottish Executive Policy

There are a variety of policy documents that relate to mentally disordered offenders in Scotland. Some are generic policy documents but others relate more specifically to people with personality disorders.

2.3.1 Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland (Scottish Office, MEL (5), 1999)

This sets out the guiding principles for the care and treatment of mentally disorder offenders in Scotland including people with personality disorders. Specifically it recognises that people with personality disorders are not a homogeneous group and can present particular problems alongside the care of other mentally disordered offenders. It acknowledges that people with a personality disorder who offend are usually dealt with by the criminal justice system and encourages prolonged assessment by means of an interim hospital order if a recommendation to court for a final disposal to psychiatric hospital is being considered.

2.3.2 Serious violent and sexual offenders: The MacLean Committee (Scottish Executive, 2001)

Established by the Scottish Executive in 1999, the MacLean Committee reviewed current legislation and made recommendations regarding the sentencing, management and treatment of serious sexual and violent offenders.

Its remit was:

> "To consider experience in Scotland and elsewhere and to make proposals for the sentencing disposals for, and the future management and treatment of serious sexual and violent offenders who may present a continuing danger to the public, in particular:
>
> - to consider whether the current legislative framework matches the present level of knowledge of the subject, provides the courts with an appropriate range of options and affords the general public adequate protection from these offenders;
> - to compare practice, diagnosis and treatment with that elsewhere, to build on current expertise and research to inform the development of a medical protocol to respond to the needs of personality disordered offenders;
> - to specify the services required by this group of offenders and the means of delivery;
> - to consider the question of release/discharge into the community and service needs in the community for supervising those offenders."

The MacLean committee made 14 recommendations most of which have been enacted in the Criminal Justice (Scotland) Act 2003 as amendments to the Criminal Procedure (Scotland) Act 1995. These will become operational in early 2006. The principal developments are:

- The creation of the Risk Management Authority (RMA)
  This will have responsibility for setting standards, guidelines and guidance for risk assessment and risk management, training and accreditation, and policy and research.

- The introduction of a Risk Assessment Order (RAO)
  This is a 90 (max. 180) day period of assessment to allow the preparation of a risk assessment report to assist the court in determining if "the nature of, or the circumstances of the commission of, the offence of which the convicted person has been found guilty either in themselves or as part of a pattern of behaviour are such as to demonstrate that there is a likelihood that he, if at liberty, will seriously endanger the lives, or physical or psychological well-being, of members of the public at large." An RAO can be applied by the court to an offender convicted of a serious violent or sexual offence, or an offence that endangers life. The emphasis will be on clinical risk assessment.
- The introduction of an Order for Life Long Restriction (OLR)
  This is a new lifelong sentence imposed on the basis of risk if the court believes on a balance of probabilities that the risk criteria outlined above are met. An OLR is an indeterminate prison sentence although a tariff will be set by the court. Release following the set prison period will be dependent on an updated risk assessment and a proposed management plan as approved by the RMA. The Parole Board will impose licence conditions in the community.
  An OLR can be applied to a mentally disorder offender given a hospital direction (an initial period in hospital combined with a prison sentence) who fulfils the risk criteria outlined above. This is not the case for patients given a compulsion order with or without restrictions on discharge. Decisions on recommendations of these various psychiatric disposals should be based on the link between an individual's mental disorder, his index offence and future risk because of that mental disorder.

The major differences between the Scottish approach to dealing with serious violent and sexual offenders and that of England and Wales are important to note. The MacLean Committee was required to consider issues surrounding offenders with personality disorders and "concluded that a third way approach in Scotland was neither feasible nor advantageous and that if offenders with personality disorders are assessed as high risk they should be managed along the lines recommended for other high-risk offenders".

The MacLean recommendations will have a significant impact on the management of people, including some with mental disorder, who commit serious violent or sexual offences in Scotland. The emphasis will be on offence and risk, rather than on a diagnosis such as psychopathy or severe personality disorder. In England and Wales, specific units for people with dangerous and severe personality disorder have been established.

2.3.3 Reducing the Risk – Improving the response to sex offending (Scottish Executive, 2001)

The expert panel on Sex Offending was established in 1998. Many sex offenders will also have a personality disorder. The primary remit of the committee was to:

- Take forward work on the recommendations of the report 'A Commitment to Protect' as directed by the Chairman of the Panel; and
- Advise the Secretary of State on any other relevant issues relating to sex offenders.

The Cosgrove committee identified a number of measures to strengthen the response to sex offending in Scotland and to provide a framework to deliver a change for the better. It made no recommendations specifically on the issue of sex offenders with a personality disorder. The committee stated that there is a need for:

- Improved understanding within communities about sex offending and the positive involvement of communities in the development of local strategies for the management of sex offenders;
- Better protection through the development of education based programmes and the provision of public information which deals with the dangers of sex offending
- A more consistent approach to risk assessment through the use of the structured clinical judgement approach;
- Wider provision of personal change programmes and greater monitoring of their effectiveness and availability;
- A more robust legislative framework to deal with the monitoring of sex offenders;
- Improvements in the quality and flow of information about individual sex offenders;
- Greater clarity about the contribution of individual agencies and a more collaborative approach to the delivery of services;
- Continued development of quality standards, particularly for training, both within and across agencies, delivered within a more structured framework.

Reflecting these priorities recommendations were made across 6 areas: community and personal safety and prevention; risk assessment; access to personal change programmes; monitoring sex offenders; housing provision for sex offenders; and information management.

2.4 Non Forensic Personality Disorder in Scotland

It is recognised that the assessment and management of people with personality disorder is an issue for mental health and social services as a whole, and is not solely the remit of forensic services, and in November 2004 a conference was convened to look at these wider issues within Scotland. It produced the following discussion paper on delivering improved care:

Personality Disorder in Scotland: Demanding patients or deserving people? (Centre for Change and Innovation, 2005)

A number of key issues were identified: service organisation, changing attitudes, training and support, early intervention, monitoring and evaluation, networking and sharing good practice, mapping existing services, research and ring fenced resources. Phased interventions were proposed: firstly, changing attitudes and re-skilling staff; secondly building on current services, and thirdly redesigning services. This document was widely circulated for discussion.

2.4.1 Conclusion

The Forensic Network should track any proposals arising from the work of the Centre for Change and Innovation and the Scottish Executive in the assessment and management of people with personality disorder in all fields of mental health throughout Scotland (recommendation 3).

2.5 Services for People with Personality Disorder in England and Wales

There has been considerable development in services for the assessment and treatment of people with personality disorder in recent years in England and Wales. These are described in Appendix B. In summary the developments include:

- Rejection of personality disorder as a diagnosis of exclusion (NIMHE, 2003a)
- The creation of the Multiagency Public Protection Arrangements (MAPPA) which require police, probation and prison officers to work together to manage the risks posed by dangerous offenders in the community (Home Office, 2003). There is a statutory duty for health, housing, social services, education, social security and employment services, youth offending teams and electronic monitoring providers to cooperate with area Multiagency Public Protection Panels (MAPPPs) which have four core functions:
    - i. Identification of MAPPA offenders
    - ii. Sharing of relevant information
    - iii. Assessment of risk of serious harm
    - iv. Management of risk of serious harm
- Investment by the Department of Health and the Home Office in establishing pilot services for people with personality disorder in general psychiatric and forensic services
- The development of pilot community forensic personality disorder services.
- The development of five inpatient forensic personality disorder units.
- The development of the concept of Dangerous and Severe Personality Disorder (DSPD). The dangerousness criterion is rated using formal risk assessment measures and the severity criterion is fulfilled by:
    - i. PCL–R score of 30 or above (or the PCL-SV equivalent) or;
    - ii. PCL-R score of 25-29 (or the PCL-SV equivalent) plus at least one DSM IV personality diagnosis other than antisocial personality disorder; or
    - iii. Two or more DSM IV personality disorder diagnoses
- The development of four Dangerous and Severe Personality Disorder (DSPD) Units: 2 in prison and 2 in high security hospitals.
- The continued role of HMP Grendon as a therapeutic community for prisoners with challenging behaviours within the prison service.

Offenders with personality disorder who represent a significant risk of serious harm to others are included in MAPPA. Such a system shares risk between different professional groups and allows the development of risk management plans across many areas of an individual's life. If we wish to encourage the involvement of health and social services staff in the assessment and management of individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system, we need to develop a similar system of information sharing, risk assessment and risk management in Scotland. It seemed to the group that with the recent creation of a Risk Management Authority, that this was an area of work that the RMA should develop.

2.5.1 Conclusions

Personality Disorder should not be a diagnosis of exclusion from forensic mental health services in Scotland (recommendation 1).

The Risk Management Authority should be given the powers to develop arrangements similar to those provided by Multi Agency Public Protection Panels in England and Wales to encourage the involvement of health and social services staff in the assessment and management of individuals with forensic personality disorder in the community by the development of a system of information sharing, responsibility sharing, risk assessment and risk management. To successfully engage staff in working with people with forensic personality disorder, and thereby increase the likelihood of improved public safety, it is essential that a culture of information exchange and shared responsibility is developed, and that a blame culture is avoided (recommendation 12).

The Forensic network should monitor the outcome of the pilot community, inpatient and DSPD services and units being currently being established in England and Wales before considering any change to current clinical practice. Any future developments of inpatient units for people with a primary diagnosis of personality disorder in Scotland must include clearly defined routes to lower security and to the community (recommendations 14 and 16).

3 CLASSIFICATION OF PERSONALITY DISORDER

A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (American Psychiatric Association, 2000).

Normal personality is best described and classified in terms of dimensions or traits, for example the degree of introversion or extroversion. At the present time however, psychiatric classifications of personality disorder are categorical and due to their heterogeneous origins there is overlap between the criteria for some categories and it is relatively common for individuals to meet the criteria for more than one category of personality disorder.

3.1 ICD-10 and DSM-IV

The personality disorder categories in ICD-10 and DSM-IV are set out in Table 2 below. The two schemes are similar, but there are categories that appear in one but not the other, and for some categories different terms are used. DSM-IV uses 3 broader clusters to organize the categories of personality disorder: cluster A (odd/eccentric), cluster B (flamboyant/dramatic) and cluster C (fearful/anxious). Although this may seem sensible, there is no particular validity to this clustering.

Each category has a list of features, a number of which should be present for the person to be diagnosed as manifesting that particular aspect of personality disorder. In addition, any diagnosis of a personality disorder should encompass core features (ICD-10):

- Evidence that the individual's characteristic and enduring patterns of inner experience and behaviour as a whole deviate markedly from the culturally expected and accepted range (or norm). Deviation in more than one of :
  1. Cognition
  2. Affectivity
  3. Control over impulses and gratification of needs
  4. Manner of relating and handling interpersonal situations
- Inflexible, maladaptive or otherwise dysfunctional behaviour across a range of personal and social situations.
- Personal distress and/or adverse impact on a social environment due to the dysfunctional behaviour.
- Evidence that deviation is stable and of long duration, having its onset in late childhood or adolescence.
- Any deviation is not explained by other mental disorders or organic brain disease.

DSM III (and subsequent editions) placed personality disorder on a separate axis (along with other developmental disorders in axis II) from mental illness (axis I).

Table 2 Personality Disorders

ICD-10	DSM-IV	Description
Paranoid	Paranoid	Sensitive, suspicious, preoccupied with conspiratorial explanations, self-referential, distrust of others.
Schizoid	Schizoid	Emotionally cold, detachment, lack of interest in others, excessive introspection and fantasy.
(Schizotypal disorder classified with schizophrenia and related disorders)	Schizotypal	Interpersonal discomfort with peculiar ideas, perceptions, appearance and behaviour.
Dissocial	Antisocial	Callous lack of concern for others, irresponsibility, irritability, aggression, inability to maintain enduring relationships, disregard and violation of others' rights, evidence of childhood conduct disorder.
Emotionally unstable – impulsive type	-	Inability to control anger or plan, with unpredictable affect and behaviour.
Emotionally unstable – borderline type	Borderline	Unclear identity, intense and unstable relationships, unpredictable affect, threats or acts of self-harm, impulsivity.
Histrionic	Histrionic	Self-dramatisation, shallow affect, egocentricity, craving attention and excitement, manipulative behaviour.
-	Narcissistic	Grandiosity, lack of empathy, need for admiration.
Anxious (avoidant)	Avoidant	Tension, self-consciousness, fear of negative evaluation by others, timid, insecure.
Anankastic	Obsessive-compulsive	Doubt, indecisiveness, caution, pedantry, rigidity, perfectionism, preoccupation with orderliness and control.
Dependent	Dependent	Clinging, submissive, excess need for care, feels helpless when not in relationship.

3.2 Psychopathy and 'Severe' Personality Disorder

Psychopathy

The terms 'psychopathy', 'psychopathic personality disorder', 'psychopathic disorder' and 'psychopath' have dominated much of the personality disorder literature until relatively recently. The term has been used in various ways, but there are probably only two legitimate ways in which these terms should be used:

- The legal category of 'psychopathic disorder' under the Mental Health Act 1983 (in England and Wales).
- 'Psychopathy' as defined by the Psychopathy Checklist-Revised (PCL-R), which is an extreme form of antisocial or dissocial personality disorder.

Psychopathic disorder under the Mental Health Act 1983

Psychopathic disorder is one of four categories of mental disorder under the Mental Health Act 1983, defined as *'a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned'*. Patients detained under this category display a range of personality and other pathology. Only a minority are 'psychopaths' as defined below. An identical category exists under the Mental Health (Scotland) Act 1984, but is not labeled 'psychopathic'.

Psychopathy checklist-revised (PCL-R)

In 'The Mask of Sanity' Cleckley (1941) described various features of psychopathy referring to cold, callous, self-centred, predatory, parasitic individuals. This concept has led to the development of the PCL-R, which measures the extent to which a person manifests the features of this prototypical psychopath. Psychopathy as defined by the PCL-R is strongly correlated with risk of future violence. It defines a narrower group of individuals than antisocial or dissocial personality disorder, and individuals scoring highly commonly fulfill the criteria for antisocial, narcissistic, histrionic, paranoid and perhaps borderline categories in DSM-IV.

The items of the PCL-R cover the affective, interpersonal and behavioural features of psychopathy. Assessment is based on a comprehensive records review and in depth interview(s). Each item is rated 0 (absent), 1 (some evidence but not enough to be clearly present) or 2 (definitely present). There are detailed descriptions of each item in the coding manual. The summed score (out of 40) gives an indication of the extent to which a person is psychopathic and may be converted into a percentile using reference tables for different populations. In North America a score of 30 or above is used as a cut-off to diagnose 'psychopathy'. In the United Kingdom this cut-off is 25 or above (Cooke and Michie, 1999).

PCL-R items

1. Glibness/superficial charm
2. Grandiose sense of self-worth
3. Need for stimulation / proneness to boredom
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse or guilt
7. Shallow affect
8. Callous/lack of empathy
9. Parasitic lifestyle
10. Poor behavioral control
11. Promiscuous sexual behavior
12. Early behavior problems
13. Lack of realistic, long-term goals
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for own actions
17. Many short-term marital relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility

Severe personality disorder

The term 'severe personality disorder' is often used but has no clear meaning or definition. Severity of personality disorder has been defined in various ways:

- in terms of severe impact on social functioning
- by using the PCL-R cut-off and being synonymous with psychopathy
- by defining severity as the presence of features fulfilling the criteria for multiple categories of DSM-IV or ICD-10 personality disorders (sometimes this is further defined by stating that the categories should be from at least 2 DSM-IV clusters, and perhaps that one must be from cluster B)
- Dangerous and severe personality disorder is defined under Services for People with Personality Disorder in England and Wales.

None of these approaches is entirely satisfactory, and each defines different but overlapping groups of individuals.

3.3 Conclusions

The Working Group recognized the current deficiencies in the concept of personality disorder and the need for a consistent assessment process to help address these (recommendations 5-7).

4 PREVALENCE OF PERSONALITY DISORDERS

To determine any plan for services or strategies for people with personality disorder in Scotland it is necessary to consider the prevalence of personality disorders in different settings and in different populations. Where possible prevalence figures relating to Scotland are shown. The challenges of accurately determining the prevalence of personality disorders have been well documented (Moran, 1999).

Data from ISD (personal communication, 2005) show that there were 1554 discharge episodes in 2000 of psychiatric inpatients with a primary or secondary diagnosis of personality disorder. Five percent (5.1%) of all discharges, or 6.1% of all discharges excluding cases of dementia, had any diagnosis of personality disorder. No statistics were available regarding outpatients. These findings are discrepant with the data for the prevalence of personality disorder in secondary care (36-81%) shown in table 3. There are a number of possible explanations for this discrepancy including a failure to record or to diagnose personality disorder. These in turn may be due to lack of training, avoidance of perceived stigmatisation or rejection of the diagnosis secondary to therapeutic nihilism.

Table 3 Prevalence of Personality Disorder

Personality Disorder	Instrument / Method	Location	Prevalence	Reference
Any	Systematic Review	General Population	6-15%	Royal College of Psychiatrists (1999)
Any	PSE ICD-9 PAS	Primary Care	6-28%	Casey & Tyrer (1990)
Any	Systematic Review	Secondary Care	36-81%	De Girolamo & Dotto (2000)
ASPD	Systematic Review	Community – worldwide	2-3%	Moran (1999)
ASPD	SCID-II	Prison – England and Wales	78% male remand 64% male sentenced 50% women	Singleton et al (1998)
ASPD	SCID-II	HMP Barlinnie	82% male special programme attendees	Bartlett et al (2001)
ASPD	SCID-II PCL-R>=30	Male special units	84% 73%	Coid (2002)
Legal psychopaths	Mental Health Act 1983	Special Hospitals	26.3%	Special Hospitals Service Authority, 1995
ASPD	Feighner Criteria	State Hospital N=241	Primary dx - 5.4% Secondary dx - 27%	Thomson et al (1997)

ASPD Borderline Schizoid Paranoid Avoidant Psychopathy	IPDE PCL-R>=25	State Hospital N=60	Second dx - 42% - 12% - 10% - 8% - 10% - 15%	Blackburn et al (2003)
Any ASPD	Systematic Review	Substance Abusers	56.5% 22.9%	Verheul (2001)

Table 3 highlights the frequency with which a diagnosis of antisocial personality disorder can be made in a prison setting. It demonstrates that although a primary diagnosis of ASPD in the special secure setting in Scotland is rare, secondary diagnoses are relatively common. Lastly, it demonstrates the association between personality disorder and substance abuse.

4.1 Conclusions

Services for people with personality disorders are required given the frequency with which they are found in the criminal justice and mental health systems in Scotland (recommendation 2).

There is evidence to suggest that services fail to record or diagnose personality disorder in the inpatient population and this should be improved (recommendations 5-7).

Data collection systems should be improved to provide accurate information on forensic personality disorder for service planning (recommendation 4).

Services for patients with a primary, and secondary, diagnosis of personality disorder are required at the State Hospital (recommendations 17-21).

.

5 ASSESSMENT OF PERSONALITY DISORDER INCLUDING RISK OF HARM TO OTHERS

5.1 Problems in assessing personality in patients with other mental disorders

The current state of classification and understanding of the aetiology and pathogenesis of mental disorders is such that most psychiatric diagnoses are based on descriptive criteria. It is common to find that an individual meets the criteria for an axis I disorder along with a personality disorder. At one extreme both may be a manifestation of the same underlying condition, at the other they may represent two completely separate aetio-pathogenic entities.

A number of problems may arise in the diagnosis of personality disorder in people who appear to have axis I disorders (mental illness): underlying personality disorder may be missed as assessment may focus on the current mental state disorder; personality disorder may be misdiagnosed as axis I disorder; and in an individual with personality disorder an axis I disorder may be missed or misconstrued as being part of the personality disorder.

In such cases it is important to remember that axis I pathology is common in people with personality disorders and any change in the presentation of a patient with personality disorder may be due to this. Equally it is important to base assessment of personality on information (preferably from a number of sources) on the pre-morbid functioning of an individual, rather than on their current functioning or just their own account of their previous functioning (their memory or interpretation of which may be coloured by their current mental state).

There are a number of potential pitfalls in the assessment and diagnosis of personality disordered patients:

- Relying on diagnoses made by others
- Failing to recognise co-morbidity.
- Misdiagnosing personality disorder as mental illness and vice versa.
- Inadequate information.
- Counter-transference (basing diagnosis on your negative reaction to a patient rather than on an objective assessment; transference and counter transference may be a part of this but negative feelings towards an individual should not be the primary basis for a diagnosis of personality disorder).
- Applying ICD-10 or DSM-IV categories without a broader assessment of personality.

5.2 Making the diagnosis of personality disorder

A clinical diagnosis of personality disorder should be based on an accurate assessment of a person's enduring and pervasive patterns of emotional expression, interpersonal relationships, social functioning, and views of self and others when they are not suffering from another mental disorder.

Information from sources other than the patient will be essential. Potential sources of information include: clinical interviews (perhaps repeated), observation (usually

repeated); previous records (medical, prison, school, social work); independent accounts (perhaps from several sources such as relatives and other professionals).

Information from various areas of the psychiatric history (childhood and adolescence; work record; forensic history / other aggression or violence; relationship history; psychiatric contact / self-harm) will give an indication of a person's personality and whether it may be disordered.

In addition specific enquiry can be made regarding the following aspects of personality: interests and activities; relationships; mood/emotions; attitudes (religious, moral, health); self-concept; coping with difficulties; specific characteristics or traits (perhaps based on personality disorder categories); include both positive and negative aspects.

In describing personality and personality disorder, first the features of a person's personality should be described; then a decision should be made as to whether the degree of distress and disruption due to personality traits is such as to indicate the presence of personality disorder; then the features that are pathological should be described. When making categorical diagnoses, the category or categories for which the criteria are met may be stated.

5.3 Instruments to assess personality disorder

There are a number of instruments available for assessing personality disorder. Such instruments are mainly used in research and are rarely used in clinical practice. Most require training and some take a considerable amount of time to complete.

- Self-report questionnaires Millon Clinical Multiaxial Inventory (MCMI) (Millon et al. 1997), Personality Disorder Questionnaire (PDQ-IV), Wisconsin Personality Inventory (WISPI) (Klein et al 1993)
- Structured clinical interviews with patient only Structured Clinical Interview for DSM-IV Personality Disorder (SCID-II) (First et al 1995), Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV) (Pfohl et al (1995)
- Structured clinical interviews with informant only Standardized Assessment of Personality (SAP) (Mann et al, 1981)
- Structured clinical interviews with patient and/or informant Personality Assessment Schedule (PAS) (Tyrer et al (1998b), Structured Interview for DSM-IV Personality Disorders (SIDP-IV) (Pfohl et al, 1995), International Personality Disorder Examination (IPDE) (Loranger et al, 1994)
- Instruments assessing specific personality disorders Schedule for Interviewing Borderlines (SIB) (Baron 1981), Diagnostic Interview for Borderline Patients (DIB) (Gunderson et al 1981), Borderline Personality Disorder Scale (BPD-Scale) (Perry 1982), Psychopathy Checklist-Revised (PCL-R) (Hare 1991), Psychopathy Checklist-Screening Version (PCL-SV), Schedule for Schizotypal Personalities (SSP) (Baron et al, 1981).
- Diagnostic instruments including an assessment of antisocial personality disorder Diagnostic Interview Schedule (DIS) (Robins et al, 1979), Feighner Diagnostic Criteria (Robins and Guze, 1972).

5.4 Functional assessment of Personality Disorder

The functional assessment of personality and associated problems has been proposed as a useful clinical approach which can produce a formulation identifying issues to be addressed in management.

- List abnormal personality traits thoughts about self and others (e.g. identity problems, paranoia, grandiosity, magical thinking, exaggerating, suggestibility, preoccupation with death, obsessionality, self-esteem), feelings and emotions (e.g. depression, elation, mood instability, callousness, loneliness, anger, irritability), behaviour (e.g. stubbornness, quarrelsomeness, sadism, self-destructiveness, compliance, impulsivity, theatricality, attention seeking), social functioning (e.g. social isolation, controlling others, dependence on others, mistrust of others, inviting rejection, forming unstable intense relationships, manipulating and using others), insight (including the ability to understand and integrate one's thoughts, feelings and actions)
- Describe associated distress and comorbid axis I disorders
- Describe interference with functioning occupational, family and relationships, offending/violence

5.5 Assessment of risk of harm to others in people with personality disorder

Any assessment of personality disorder should include an assessment of risk of harm to others. Risk assessment has been defined by Stephen Hart as 'the process of evaluating individuals to characterise the likelihood they will commit acts of violence and develop interventions to reduce that likelihood.' This definition was employed by the MacLean Committee and is considered to be the underlying philosophy of risk assessment in a number of forensic mental health services in Scotland. 'Risk' is a dynamic concept which fluctuates according to time, environment, the individuals involved and a person's current mental state. Therefore, risk should not be viewed as present or absent, but as a hazard that can be increased or reduced according to a variety of factors which include:

History of:

- Previous violence;
- Adverse childhood experiences;
- Behavioural problems in childhood;
- Social instability (eg. poor employment history, unsettled relationships)
- Substance abuse;
- self-harm;
- impulsive behaviour;
- Poor compliance or response to treatment

Presence of:

- persecutory delusions
- command hallucinations
- passivity
- irritability

- anger
- hostility
- suspiciousness
- lack of insight
- specific threat(s)
- identified precipitant(s) /stressor(s)

Prediction of risk on a clinical basis alone is poor although this may be improved through greater awareness of factors associated with risk and violence. The poor predictive quality of clinical judgement has fostered attempts to produce more accurate methods of risk assessment leading to the development of actuarial and structured clinical risk assessments. It is important to note that much of the research focus in this field has been on men rather than women.

5.5.1 Actuarial Assessment

Actuarial risk assessment uses statistical methods to examine the variables that are known to predict violence in practice. It is a good predictor of long term risk and can be used as a screening tool to identify high risk individuals. These variables are weighted according to those with greatest predictive power and combined to give a summated risk assessment score. Actuarial risk assessments focus on historical factors in an individual's history, with little weight given to dynamic factors such as a change in clinical presentation. Therefore, once a risk "score" has been given, there is little scope for its future alteration. The ability of actuarial risk assessment being relevant in environments other than those in which they were developed has been questioned (Monahan, 2001) and actuarial assessments are unable to take account of specific variables that overrule the static risk factors associated with actuarial assessment such as specified threat against an individual or severe physical impairment. Whilst actuarial assessment can determine an individual's long-term risk, it has little ability to predict current risk, a function that is more accurately predict using a form of dynamic risk assessment. Such criticisms of actuarial risk assessment have led to the development of an alternative mode of assessment, known as structured risk assessment (many but not all of which combine actuarial and dynamic risk assessment), which aims to combine both a valid assessment and management tool.

5.5.2 Structured clinical judgement

Structured clinical judgement or risk assessment combines actuarial risk factors with dynamic factors, that is factors that are not static and are likely to change over the course of time. Whilst dynamic factors are present in actuarial assessments, the weight given to such factors is minimal. Given the nature of the population the likelihood for co-morbid psychiatric illness, especially within the forensic services in Scotland (Thomson et al. 1997), attention to dynamic risk factors is viewed by many as a vital component of a comprehensive risk assessment.

In Scotland Cooke et al. (2001) carried out an evaluation of risk assessment measures in a Scottish Prison sample comparing the HCR-20, PCL-R and VRAG. They found the predictive utility of these instruments was similar to that of other studies in differing environments. They concluded that whilst the HCR-20 is not superior to the other instruments in terms of predictive utility, it is advantageous as it also provides guidance on management as well as the level of risk.

Other actuarial and dynamic risk assessments also exist. A comprehensive list of dynamic and actuarial risk assessments is listed in Table 4 below (Thomson, 2005).

Table 4 Actuarial and Dynamic Risk Assessment Instruments

Instrument	Assessment	Type	Target population
Violence Risk Appraisal Guide (VRAG) Quinsey et al. (1998)	Risk of violence	Actuarial	Mentally disordered male offenders
Historical Clinical Risk-20 (HCR-20) Webster et al. (1997)	Risk of violence	Structured Clinical	Any population with high proportion of people with violent histories, and a suggestion of mental illness or personality disorder.
Iterative Classification Trees (ICTs) Monahan et al. (2001)	Risk of violence	Actuarially determined algorithms	Civil psychiatric patients in community settings
Violence Risk Scale (VRS) Wong & Gordon (2000)	Risk of violence	Structured professional	Violent offenders
Spousal Assault Risk Assessment Guide (SARA) Kropp et al. (2000)	Risk of spousal assault	Structured Clinical	Any individual (male or female) who is accused of assaulting their intimate current or former partner
Level of Service Inventory-Revised (LSI-R) Andrews et al. (1995)	Risk of recidivism and needs	Structured Clinical / Needs Assessment	Offenders in prison or on probation
Offender Group Reconviction Scale (OGRS) Copas & Marshall (1998)	Risk of reconviction during 2 years after release from prison or community sentence	Actuarial	Offenders being released from prison, or serving a community sentence
Risk Assessment Guidance Framework (RAGF) Social Work Services Inspectorate (2000)	Criminogenic needs, risk of reconviction and risk of harm to others	Structured Clinical	Offenders receiving a criminal justice social work assessment
Risk of Reconviction (ROR) Copas et al. (1996)	Risk of reconviction during 2 years after release from prison	Actuarial	Male offenders released from prison, (approximation given for females) – parole decisions
Offender Assessment System (OASys) Home Office (2002)	Risk of violence	Structured professional	Offenders in prison or probation system

Sexual Offender Risk Appraisal Guide (SORAG) Quinsey et al. (1998)	Risk of violence	Actuarial	Mentally disordered male, sexual offenders
Sexual Violence Risk-20 (SVR-20) Boer et al. (1997)	Risk of sexual violence	Structured Clinical	Individuals who have committed, or are alleged to have committed, a sexual offence
Structured Assessment of Risk and Need (SARN) Mann et al (2002)	Change in risk of sexual violence	Structured Clinical	Sexual offenders
Risk of Sexual Violence Protocol (RSVP) Hart et al. (2003)	Risk of sexual violence	Structured Clinical	Individuals who have committed, or are alleged to have committed, a sexual offence
Sex Offender Needs Assessment Rating (SONAR) Hanson & Harris (2001)	Change in risk of sexual violence	Actuarial	Sexual offenders
Rapid Risk Assessment for Sexual Offence Recidivism (RRASOR) Hanson (1997)	Risk of sexual violence	Actuarial	Adult (18+) male sexual offenders (at least one sex offence conviction)
Structured Anchored Clinical Judgement (SACJ) Hanson & Thornton (2000)	Risk of sexual violence	Actuarial	Sexual offenders (3rd part can only be completed for those offenders who have entered treatment programmes)
Static-99 Hanson et al. (2000)	Risk of sexual violence	Actuarial	Adult (18+) male sexual offenders (at least one sex offence conviction)
Risk Matrix 2000 Thornton et al. (2003)	Risk of sexual and non-sexual violence	Actuarial	Adult (18+) male sexual offenders (at least one sex offence conviction)

As there are no specific services for offenders with personality disorders in Scotland, little specific information can be given about the existing use of structured risk assessments throughout all the organisations that work with individuals with personality disorder. A list of assessments used by the Scottish Prison Service (SPS) is however available (see section 9 for further information). Services for DSPD in England have evolved structured risk assessment protocols throughout their practice (Table 5).

Table 5 Risk Assessment Protocol used in DSPD Units

Risk Assessment Tools
Violence
VRS
HCR-20
Sexual Offending
Risk matrix 2000
Static 99
SARN
Personality Disorder
PCL-(R)/PCL- (SV)
IPDE
Mental Illness
SC1D-1

5.6 Conclusions

A diagnosis of personality disorder (primary or secondary) should be considered during all forensic mental health consultations (recommendation 5).

The assessment of personality disorder should ideally be multidisciplinary and include (recommendation 6):

- **an emphasis on third party information**
- **assessment for the presence of axis I disorders**
- **use of standardized measures of personality disorder**
- **assessment of risk of harm to others using standardized measures**
- **a formulation of symptoms and behaviours associated with the personality disorder**

Suggested assessment measures include (recommendation 7):

- **Personality Disorder**
  - Clinical assessment based on ICD-10 (World Health Organisation, 1992) or DSM-IV criteria (American Psychiatric Association, 1994)
  - International Personality Disorder Examination (Loranger et al, 1994)
  - Psychopathy Checklist-Revised (Hare, 1991) or ScreeningVersion
- **Mental Illness**
  - Clinical ICD-10 (World Health Organisation, 1992)
- **Risk of Violence**
  - Historical Clinical Risk 20 (Webster et al, 1997)
- **Risk of Sexual Offending**
  - Risk of Sexual Violence Protocol (Hart, 2003)
  - Risk Matrix 2000 (Boer et al, 1997)

6. TREATMENT AND MANAGEMENT OF PERSONALITY DISORDERS

6.1 Treatment Model

The treatment and management of people with forensic personality disorder is an area of great debate. Some believe that it is inappropriate to manage people with personality disorder within the mental health legislative framework (Chiswick, 1992) while others believe that people with personality disorder should not be treated any differently from those with mental illness (Gunn, 1992). The Working Group did not commission a systematic literature review but utilised recently published reviews and the knowledge of its members.

Major mental illness such as schizophrenia is manifestly different from personality disorder. The symptoms and signs of schizophrenia are recognisable, if not understandable, to a lay person. This is not the case for personality disorder. Nor is the evidence for successful treatment and management strategies for personality disorder as clear cut. Patients with a primary diagnosis of personality disorder are admitted to hospital infrequently. Possibly the most helpful way to consider the assessment and management of personality disorder is to compare it with substance abuse. Like substance abuse, personality disorder is prevalent within our society and some subtypes are associated with violent offending; its origins may lie in genetics, and in deprived and abusive childhoods; and prevention is a better strategy than cure. In our society those who abuse substances are held responsible for their actions, and offences are dealt with through the criminal justice system and seldom diverted to mental health. Criminal justice sanctions can be used to assist in the management of substance abuse, for example drug treatment and testing orders or a condition of probation to attend for treatment at an alcohol problems clinic. Substance abuse alone, cannot justify detention in hospital under mental health legislation.

A wide range of treatment options is available for substance abuse, involving health, social services and the voluntary sector; in a variety of settings including the community, hospital and prison. Hospital treatment is always on a voluntary basis although complications of substance abuse, for example a drug induced psychosis or alcohol hallucinosis may be treated using mental health legislation in hospital generally on a short-term basis. In a similar way, individuals with complications of a personality disorder, for example a psychotic episode associated with a paranoid personality disorder or an episode of depression accompanied by suicidal ideation associated with a borderline personality disorder, can be admitted to hospital compulsorily but usually on a short-term basis.

Behavioural interventions may provide the best solution in the current state of knowledge about diagnosis because they are problem-focussed and concentrate on specific outcomes. For example, repeated episodes of violence may respond to anger management, and if associated with substance abuse, specific treatments for this. Some forensic services offer assessment and treatment on the basis of a specific problem behaviour rather than a specific diagnosis. Within the State of Victoria in Australia, the forensic service has established a problem behaviours clinic that offers assessment and treatment to stalkers, threateners, persistent complainants, violent and sexual offenders. By focussing less on diagnostic categories, behavioural

interventions neither stigmatise the person by labelling, nor conversely offer them a 'mental illness' to hide behind. While a number of different models of psychological intervention exist, there are circumstances which enhance the likelihood of effective outcomes: (1) There should be an effective therapeutic relationship, based on openness and collaboration rather than power; (2) there is a need for the individual to accept responsibility for change; and (3) there is a need for the goals or targets for intervention to be explicit (Roth, 2005). From a psychological perspective, individuals with forensic personality disorder present with a range of complex and interacting psychological problems. The question should not be about 'treatability' of personality disorder as a whole, but rather about directing treatments at individual behavioural components of the disorder although it may be possible in future work to consider an individual's underlying schema that contributes to the personality disorder. Although a behavioural approach is recommended, it remains essential to make the diagnosis as part of an overall formulation about an individual. The diagnosis of personality disorder contributes towards understanding difficulties in engagement with therapies, splitting, manipulation and counter-transference.

In general terms, interventions for those with forensic personality disorder should address the following 'What Works' criteria: (1) they should be offence focussed (where applicable); (2) address the issue of risk reduction and recidivism; and (3) should be based on the identified needs of the group (McGuire, 1995). Roth (2005) in reviewing what works for whom, identify criteria by which psychological interventions can be considered to be effective. While acknowledging some degree of arbitrariness, they considered the following criteria as important: a) replicated demonstration of superiority to a control condition, or a single high quality randomised control trial; b) the availability of a clear description of the therapeutic method of sufficient clarity to be usable for the basis of training and replication of trials; c) a clear description of the patient group to whom the treatment was applied; d) delivery by competently trained and supervised staff; and e) research effort indicating some evidence of efficacy.

It is therefore clear, that interventions for people with forensic personality disorder need to be based upon the following principles. They must be:

a) Needs led
b) Protocol driven
c) Evidence based
d) Derived from 'best practice'
e) Clinically effective
f) Aimed at restoring self respect
g) Aimed at reducing the risk for further offending to manageable proportions.

6.2 Psychological Interventions for Personality Disorder

Reviews of the effectiveness of psychological interventions with personality disorders have been carried out (Warren et al, 2003; Woods and Richards 2002; Bateman and Tyrer, 2004). The general quality of the literature on these interventions falls short of gold standard research and most studies to date have significant methodological problems. Most have examined interventions with borderline personality disorder. These studies have provided some encouraging evidence that some patients with personality disorder may respond to treatment. For example, there is some evidence for the use of dialectical behaviour therapy in borderline personality disorder (Linehan et al, 1991), for partial hospitalisation (Bateman and Fonagy, 1999) and for psychodynamic psychotherapy (Munro Blum and Marziali, 1995; Roth, 2005). Different types of personality disorder appear to be associated with treatment-seeking or treatment-resisting behaviour. Typically paranoid, antisocial and schizoid personality disorders are more often treatment-resistant whereas borderline personality disorder is most often treatment-seeking. It is the former group that is more often found in patients with forensic personality disorder.

A review of treatments for severe personality disorder (Warren et al, 2003) identified 117 relevant studies and concluded that there was some moderate quality evidence in high security settings for the efficacy of therapeutic communities for male personality disorder as measured by reduced recidivism; some better quality evidence in low security settings for cognitive behavioural therapy and dialectical behavioural therapy in female borderline personality disorder with reduced self-harm; and limited evidence for psychodynamic psychotherapy or pharmacological intervention. Despite a variety of psychological approaches to the treatment of ASPD and its associated problems, studies of interventions in ASPD suffer from poor methodology and a lack of assessment of relevant outcomes (Salekine, 2002; Lipton et al, 2002; Leichsenring and Leibing, 2003; Warren et al, 2003). In addition, randomised controlled trials of psychological interventions in ASPD patients living in community settings have not been conducted.

Table 6 Aims of Psychological Treatments for Personality Disorder (Bateman and Tyrer, 2004a)

Psychological Treatment	Therapy Aims
Cognitive Behavioural Therapy	To alter dysfunctional core beliefs To change behaviour
Dialectical Behaviour Therapy	To reduce self-harm and eventually to achieve transcendence
Cognitive Analytic Therapy	To achieve greater self-understanding
Dynamic Psychotherapy	To increase reflective capacity, and emotional and interpersonal understanding
Therapeutic Community	To effect attitudinal and behavioural change

It has been proposed that specialist psychological interventions for people with forensic personality disorder should in fact be no different from interventions for offenders in general. A reduction in high risk/reoffending behaviour will be a major focus of a successful outcome. Mediators of antisocial behaviours need to be identified, targeted and influenced by appropriate interventions (Blackburn, 1993). With regards to antisocial behaviours, the main approaches that appear to work are cognitive-behavioural in nature (Andrews et al, 1990) and include social skills and problem-solving training. McMurran (2003) emphasised the importance of two findings from research with offenders: (1) interventions based on a conceptual model are more likely to be effective, and (2) individual criminogenic needs must be addressed. The State Hospital provides services to individuals suffering from personality disorder based upon these principles which address a number of their criminogenic and behavioural risk factors. Interventions available include:

a) Social Skills Training
b) Drug and Alcohol education and relapse prevention
c) Anger Management
d) Self harm reduction programmes (Dialectical Behavioural Therapy)
e) Sex Offender Programmes
f) Offender Programmes

Any treatment programme should be developed in line with the evidence based ten Home Office accreditation criteria for offending behaviour programmes and should:

- have a clear model of change (i.e. a theoretical underpinning to the programme, based on a model of personality development and disorder)
- have clear criteria for subject selection
- target relevant dynamic risk factors
- use effective methods
- teach skills that will assist individuals to avoid offending and pursue legitimate pursuits
- have a clear description of the sequencing, intensity and duration of the different components of the programme
- maximise engagement and motivation
- ensure continuity with other programmes/services
- monitor its performance
- undertake a long term-evaluation

6.3 Medication

Most evidence for the use of drug treatment for personality disorders has been gathered from the treatment of borderline personality disorder. See the guidelines of the American Psychiatric Association (2001) set out in Table 7.

Table 7 Psychopharmacological Treatment Recommendations for Affective Dysregulation Symptoms in Patients With Borderline Personality Disorder

Drug Class	Specific Medications Studied	Symptoms for Which Medication Is Recommended	Strength of Evidence[a]	Issues
SSRIs and related antidepressants	Fluoxetine, sertraline, venlafaxine[b]	Depressed mood, mood lability, rejection sensitivity, anxiety, impulsivity, self-mutilation, anger/hostility, psychoticism, and poor global functioning	A	Relatively safe in overdose; favorable side effect profile; evidence obtained from acute (6–14 weeks), continuation (up to 12 months), and maintenance (1–3 years) treatment trials; second SSRI trial may still be effective if first trial fails ("salvage strategy," strength of evidence=C)
MAOIs	Phenelzine, tranylcypromine	Mood reactivity, rejection sensitivity, impulsivity, irritability, anger/ hostility, atypical depression, hysteroid dysphoria	B	Second-line treatment after SSRI failure; complete elimination of initial SSRI required before MAOI treatment; adherence to required dietary restrictions problematic; effective for atypical depression only when borderline personality disorder is secondary, not primary, diagnosis
Mood stabilizers	Lithium carbonate	Mood lability, mood swings, anger, suicidality, impulsivity, poor global functioning	C	Can be used as primary or adjunctive treatment (overlaps with treatment of impulsive-behavioral domain); narrow margin of safety in overdose; blood level monitoring required; risk of hypothyroidism; to date, best studied of the mood stabilizers in treatment of personality disorders, but older literature focuses on reduction of impulsive behavior
	Carbamazepine	Suicidality, anxiety, anger, impulsivity	C	Efficacy in patients exhibiting hysteroid dysphoria; can precipitate melancholic depression; risk of bone marrow suppression; blood draws required to monitor WBC count

	Valproate	Global symptom severity, depressed mood, anger, impulsivity, rejection sensitivity, irritability, agitation, aggression, anxiety	C	Paucity of research support for this indication despite widespread use; blood draws required to monitor liver function
Benzodiazepines[c]	Alprazolam, clonazepam	Refractory anxiety, impulsivity, agitation	C	Risk of abuse, tolerance; alprazolam associated with behavioral dyscontrol
Neuroleptics[c]	Haloperidol	Behavioural dyscontrol, anger/hostility, assault, self-injury	A	Rapid onset of effect provides immediate control of behavior

[a] Ratings used by Jobson and Potter (2): A=supported by two or more randomized, placebo-controlled, double-blind trials; B=supported by at least one randomized, placebo-controlled, double-blind trial; C=supported by open-label studies, case reports, and studies that do not meet standards of randomized, placebo-controlled, double-blind trials. See text for specific supporting studies. [b]A mixed norepinephrine/serotonin reuptake blocker. [c]Agents primarily used as adjunctive treatment.

There are psychopharmacological arguments, if little evidence to date, for the use of medication in the treatment of symptoms and problematic behaviours associated with other personality disorders (Tyrer and Bateman, 2004). In brief, it is the type of symptom primarily presented that dictates the choice of drug:

Table 8 Psychopharmacological Treatment Options for Symptoms of Personality Disorder

Symptom	Drug
Cognitive / Perceptual	Antipsychotics
Affective dysregulation	Selective serotonin reuptake inhibitors, Monoamine oxidase inhibitors
Impulsive-behavioural dyscontrol	Mood stabilisers, Selective serotonin reuptake inhibitors

6.4 Management of Personality Disorder

The Working Group was of the view that it was more useful to consider the overall management of an individual with a personality disorder and, rather than to attempt to treat the disorder as a whole, to concentrate treatment on specific behaviours and symptoms. There is a debate about whether a specialist team can do this best (Bateman and Tyrer, 2004-b). Within forensic mental health services, however, the evidence suggests that at least one-third of patients will have a primary or secondary diagnosis of personality disorder. This suggests that all forensic practitioners should be skilled in the assessment and management of people with personality disorder.
The following components are essential to the successful management of an individual with a personality disorder:

- Multidisciplinary input

- Thorough assessment – personality, mental illness, risk, needs
- Motivation and Engagement
- Consistency and constancy of an identified team
- Inpatient support – issues of dependency, regression and behavioural deterioration in a ward setting are relevant. At times voluntary, brief, goal determined admissions may be required for crisis intervention, assessment, or stabilisation of medication in those with a primary diagnosis of personality disorder. For those with a comorbid major mental illness, the use of mental health legislation may be appropriate.
- Medication where indicated
- Identification of therapeutic needs e.g. for anger management or substance abuse education and relapse prevention programmes
- Agreed response to aggression
- Addressing social requirements – accommodation, employment, education, recreation
- Support and education for carers
- Information sharing/Management plan/Agreed lines of communication
- Agreed response to deterioration or crisis
- Implementation of the Care Programme Approach
- Review of critical incidents

6.5 Conclusions

The evidence base for the treatment of personality disorder is not strong. There is some evidence of the efficacy of structured coherent psychological approaches for people with personality disorder but the use of these and of medication for the treatment of specific symptoms is under researched. In addition, such approaches require further assessment of their effectiveness in people with a forensic personality disorder (recommendation 8).

Any treatment programme should be developed in line with the evidence based ten Home Office accreditation criteria for offending behaviour programmes as described above (recommendation 9).

Services developed for people with personality disorders should adopt a problem behaviour focus derived from a case formulation which should include a range of interventions to address the factors that underlie risk related behaviour (recommendation 10).

These services require to be developed within a range of environments including the community, hospital and prison (recommendation 11).

7. OVERVIEW OF SERVICES WITHIN THE SCOTTISH PRISON SERVICE

The Scottish Prison Service (SPS) strategy for the management of prisoners is based on the identification of problem behaviours and needs. It does not focus its management of prisoners on the concept of personality disorder, nor are the majority of its staff qualified to assess and diagnose this (Professor Roisin Hall and Ms. Diane Perera, Presentation 29/9/04). There are 3 principal structures that allow for the identification and management of prisoners with behavioural problems and needs: Sentence Management, Risk Management Groups and Mental Health Teams.

7.1 Sentence Management

Sentence management identifies an individual prisoner's criminogenic needs and targets individuals who require specialist assessment. As well as assessing individual need, the sentence management process assesses aggregated levels of need and this assists the service to prioritise resources and plan interventions effectively. All prisoners undergo an initial core screening assessment of health and social needs. Depending on the result of this assessment, a more comprehensive individual risk needs assessment may be carried out. These are formulated as a part of the sentence management process and are a comprehensive approach to evaluating the specific needs of at risk prisoners (See diagram below). Aggregated needs are placed into 3 bands of perceived risk (high, medium and low) in the following areas:- violent anger; reactive anger, inappropriate sexual conduct; substance misuse/addictions; education; employability; social and welfare needs; mental health and other criminogenic needs.

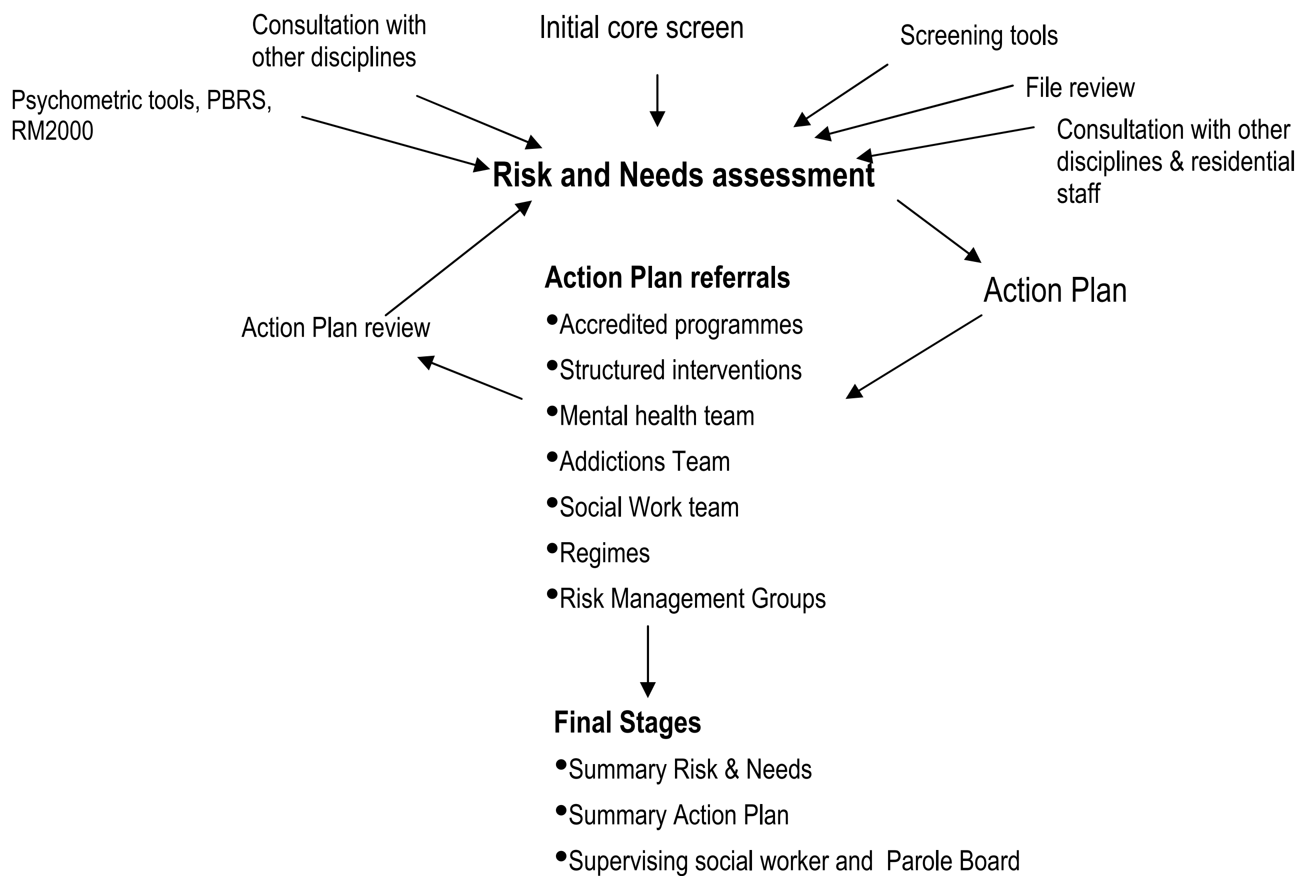


Figure 1 SPS Risk Needs and Assessment Diagram

Sentence management for long term prisoners began in 1997 but the core screen was added in 2004.

7.2 Risk Management Groups

High risk and difficult to manage prisoners are referred to Risk Management Groups. These multidisciplinary groups receive referrals from the service management teams and prison staff. The group is designed to develop enhanced action plans for example involving specific interventions, community liaison and psychological risk management. These action plans are regularly reviewed by the group. As part of the Risk Management Group assessment, a comprehensive psychological risk report is developed for each prisoner. This is accomplished through structured clinical judgement using evidence based tools and a standardised approach. The tools used include:-

- HCR-20
- SARA
- Risk Matrix 2000
- SVR-20
- RSVP
- PCL-R
- VRS

7.3 Mental Health Teams
Mental health teams exist in most Scottish prisons. Ideally their members include a psychiatrist(s), registered mental nurses, community psychiatric nurses, medical officers, a social worker(s), chaplains, psychologists, and occupational therapists. In reality, it may often be much more limited and even the registered mental nurses may be called away to carry out tasks related to physical illness. In some prisons, the mental health team meetings are chaired by a prison deputy governor and emphasise positive mental health. Most focus mainly on people suffering major mental illness rather than personality disorder.

Prevalence studies have shown that individuals with personality disorder are frequently found in prison. This is unlikely to be identified during the initial sentence management process. Personality disorder is likely to be an issue in those referred to the Risk Management Group. Its diagnosis would be of assistance in explaining the difficulties found in engaging with these individuals in productive behaviours. Likewise, such individuals will regularly attend mental health services with a variety of complaints usually related to feelings of unhappiness and low mood. A clear diagnosis again assists in their management and in expectations of change.

7.4 Interventions
A variety of CBT interventions are delivered within the SPS by prison staff. These focus on violent behaviour and sexual offending behaviour:

- **Violent behaviour is** addressed through the violence behaviour programme that is designed for individuals at highest risk of re-offending. It explores offenders' use of violence and challenges individual motivations and reasons for violence. The programme also teaches skills to replace violence with more pro-social behaviour.
- **Sexual Offending behaviour** is addressed through 4 programmes. The Sexual Treatment Offender Programme (STOP Core) programme challenges thinking patterns, and develops victim empathy and relapse prevention skills. The STOP (adapted) programme is an alternative programme that focuses on the needs of adult and young offenders with learning disabilities. The STOP 2000 (rolling) programme challenges thinking patterns, and develops victim empathy and relapse prevention skills. Finally, the STOP (extended) programme aims to develop a deeper understanding of the patterns underlying sexual offending and methods of controlling them.

7.5 Recommendations

The group supported the focus of the Scottish Prison Service during the initial sentence management process on identifying problems and needs rather than diagnosis. There is a comprehensive assessment process for identifying risk and needs and there is a structure in place to deal with those identified as high risk or problematic through the Risk Management Groups (recommendation 22).

The group recognised that the issue of personality disorder is central to many problem behaviours found in prisons, to failure to engage with therapeutic programmes and to an excessive drain on health service resources within prison by continual demands for assessment and medication. The group therefore recommended that in these contexts assessment of individuals for the presence of

personality disorder would assist in their subsequent management (recommendation 23).

The group identified a need to strengthen mental health teams within prisons. All prisons should have a multidisciplinary health team of a standard set out in the policy document "Positive Mental Health" (Scottish Prison Service, 2002). At the present time these are focussed entirely on the identification and treatment of those with mental illness, and struggle to fulfil this role. In addition, they are rarely truly multidisciplinary (recommendation 24).

The group identified a need for visiting mental health professionals to engage more widely with the therapeutic work of the prison service, including offender based programmes (recommendation 25).

One or more pilot prison and mental health team should be identified to carry out detailed assessments of problematic prisoners, and to develop management plans in conjunction with the prison's Risk Management Group. These pilots should develop clear referral criteria, an assessment battery, and an agreed management strategy tailored to each individual. Additional resources will be required. Any pilot must be evaluated (recommendation 26).

Staff training and supervision will be required to work with people with personality disorder in prison. This will be required on two levels: firstly, for staff to assess and manage these individuals; and secondly, for staff carrying out specific programmes which may contain these individuals within the prison (recommendation 27).

There is evidence from HMP Grendon that prisons or special units run on the principles of a therapeutic community can improve aggressive behaviour within that setting. It is recognised that these units require strong leadership and a clear psychotherapeutic principle basis to succeed and that focus may be lost over time. The group recommends that the Forensic Network examines the evidence, as it becomes available, from the DSPD units in England and findings from the Scottish prison pilot recommended above (26) before making any recommendation on re-establishing such units within the Scottish Prison Service (recommendation 28).

The Group acknowledged the day programme approach developed in HMP Barlinnie (Open Doors Programme) and HMP Perth for vulnerable prisoners or prisoners with major mental illness. To succeed, any such day programmes must have a defined client group and therapeutic focus, and access to multidisciplinary input. The group recommends that the Forensic Network examines the evidence, as it becomes available, from the Scottish prison pilot recommended above (26) before making any recommendation on establishing day programmes for people with personality disorder within the Scottish Prison Service (recommendation 29).

8. SPECIFIC CONSIDERATIONS

There are specific issues to be considered for women or patients with learning difficulties who have a personality disorder. For example, female patients assessed by forensic mental health services are more likely to have a borderline personality disorder and to present with self harming behaviour. The forensic managed care network commissioned reports on both of these groups. These subgroups were not included in the current remit.

8.1 Conclusions

The Forensic Network should ask the chairs and nominated members of the working groups on women and learning disability to consider the particular issue of personality disorder for their respective cohorts in light of the recommendations contained in this report (recommendation 32).

9. SURVEY OF SERVICES FOR PEOPLE WITH FORENSIC PERSONALITY DISORDER IN SCOTLAND

9.1 The Service Mapping Study

The Working Group in its remit was asked:

- To describe services currently available in Scotland for individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system
- To describe treatment strategies currently used in Scotland with this group.

To fulfil the remit, a survey on services for people in Scotland with a diagnosis of personality disorder associated with a risk of violence others was carried out. The survey :

- Mapped the services for the spectrum of personality disorders in each locality
- Addressed assessment issues
- Considered therapeutic and clinical management issues and
- Described self-assessed service competencies in line with recent NIMHE recommendations (NIMHE, 2003b)

9.2 The Participants

The survey was sent to the lead psychiatrists in each of the forensic services in Scotland. Responses were received from 10 of the 11 identified services (Ayrshire and Arran, Dumfries and Galloway, Fife, Forth Valley, Glasgow, Grampian, Highlands, South-East of Scotland, The State Hospital and West of Scotland). To augment the data, a similar survey was sent to clinical psychologists who are members of the Scottish Forensic Clinical Psychologists Interest Group. It was considered that as part of their remit, clinical psychologists may often have the task of carrying out structured personality/personality disorder assessments and providing appropriate psychological therapies to people with personality disorder. Fifteen questionnaires were distributed to Clinical Psychologists and five were returned (Glasgow, Forth Valley, Highland, The State Hospital and the Time-out service for women with drug convictions in Glasgow). The survey was distributed three times to improve response rates. The five respondents came from Western Central Scotland, with one further respondent from a rural locality. The results of the survey below may have to be interpreted cautiously, due to the fact that the role of all NHS mental health disciplines in the provision of services for personality disorder has been assessed primarily by Psychiatrists, with responses from a few Clinical Psychologists.

An adapted survey was posted to Directors of Social Work and Chief Social Work Officers throughout Scotland. A total of 46 were sent out, and 11 were returned. Respondents were asked to identify their service locality, but only two did so. Hence, the results must also be interpreted with caution, as we are unable to ascertain the areas which the respondents represented.

The Scottish Prison Service was invited to participate in the survey but considered that staff were not qualified to answer questions on personality disorder. The survey results are set out in detail in Appendix C. The main findings are summarised below:

9.3 The NHS Survey

Response Psychiatry 10/11 (90.9%) Psychology 5/15 (33.3%)

General

- 50% of NHS Services did not have either a stated philosophy of care or stated service principles. The current position and rights to services for people with personality disorder therefore appears to be unclear at a service provider level in a number of areas in Scotland.
- 7 out of the 10 services stated that they implicitly excluded people with a diagnosis of personality disorder from admission to their service.

Services

- 7 services were willing to assess the spectrum of personality disorders and one only in conjunction with a severe and enduring mental illness.
- 7 sites reported that personality disorder assessment is conducted by a multidisciplinary team.
- 8 services assessed personality disorder associated with a high risk of violence to others.
- The majority of services used comprehensive methods to collate information contributing to a diagnosis of personality disorder.
- Only 4 services used structured assessments to confirm diagnosis of a personality disorder. 2 used the International Personality Disorder Examination, which is generally considered to be the structured assessment of choice at present. Four sites reported use of the Psychopathy Checklist – Revised (PCL-R) which is one of the most important assessments of personality traits associated with risk of violent offending. These results may be explained in two main ways. Firstly, that the lack of use is a reflection of training and service development needs. Secondly, the use of these assessments requires a considerable amount of staff resources, in that comprehensive assessment of personality disorder may take several hours of a clinician's time.

Interventions

- 6 services (psychiatry) did not accept people with a primary diagnosis of personality disorder for specific intervention, treatment or management.
- 4 services (psychiatry) did not accept people with a secondary diagnosis of personality disorder for specific intervention, treatment or management.
- 5 Clinical Psychology Services accepted these groups for intervention but 2 specifically excluded people with antisocial personality disorder or a personality disorder which may pose a considerable risk of violence to others.
- The respondents were unable to provide reliable estimates of the number of individuals using their services who met diagnostic criteria for personality disorders.
- The numbers provided do not reflect the prevalence of personality disorder found in the general population or in forensic populations.

Assessment of Risk and Needs in Personality Disorder

- 9 services reported that they regularly conducted risk and needs assessments for service users with diagnosis of personality disorder.
- 9 services used comprehensive methods to collate information related to conducting a risk and needs assessment.
- 6 sites routinely structure risk assessment measures: 6 used the HCR-20, 2 the SVR-20, 3 the PCL-R, and 2 the RSVP. Given the incongruence of use of the HCR-20 with the PCL-R (only 50% of those using the HCR-20 incorporated the PCL-R into this) there is an indication that personality disorder may not be adequately considered in risk assessment and management.
- Only 1 service used a tool to formally assess needs.
- 8 services were routinely formulating risk management plans on the basis of current assessment.
- In terms of monitoring risk management, there was considerable evidence of multidisciplinary working across Scotland; but in the majority of cases, the RMO considered they had the most significant personal responsibility.
- 7 services considered the needs of service users with personality disorder complex enough to warrant the use of the Care Programme Approach.
- Only 2 localities had systems currently available in their service for the use of Integrated Care Pathways to plan and monitor care.

Therapeutic/Clinical Management Services for Clients with Personality Disorder

Table 9 outlines the services currently available to patients with a diagnosis of personality disorder throughout Scotland.

Table 9 Services Currently Available for Patients with Personality Disorder

Service	**Currently available to patient with a diagnosis of a personality disorder**
Services:	No of NHS localities in Scotland (10)
Social Work	9
Housing Support	6
Occupational Therapy	6
Nursing	10
Psychiatry	10
Psychology	8
‘Untrained’ support workers	5
Drop-in facilities	4
Client Advocacy	7
Specific Interventions:	
Drug and Alcohol services	9
Cognitive Behavioural therapy (individual basis)	7
Cognitive Behavioural therapy (group-work basis)	4
Psychotherapy (individual)	4
Psychotherapy (group)	0

Counselling	2
Dialectical behaviour therapy	2
Therapeutic Community	0
Structured Psychoeducation:	
Anger Management	9
Relapse Prevention	4
Sex Offending	4
Moral Reasoning	1
Problem-Solving Training	1
'Cognitive Skills'	3
Social Skills Training	4
Activities of daily living	8

- This simplistic service mapping provides rudimentary evidence that there are piecemeal services available to service users with a diagnosis of personality disorder throughout Scotland. While all services indicated that service users had access to Psychiatry and Nursing, their access to other services was not consistent. 9 sites had access drug and alcohol services (and indeed there are often such co-morbid problems associated with personality disorder), and 9 to specific therapeutic work around anger management.
- Access to more specific forms of therapy which are considered to have some proven efficacy for service users with a diagnosis of personality disorder were more limited with individual psychotherapy available in 6 sites, CBT at 9 sites and DBT at 2 sites.
- In terms of specialist psychological interventions associated with risk of violence, only 4 sites were able to provide appropriately tailored programmes around relapse prevention, sex offending, and problem-solving training to clients with a diagnosis of personality disorder.

Competencies and Training Needs

Promoting Social Functioning in Personality Disordered Clients

- 5 services had low confidence in their ability to support staff in maintaining positive attitudes to working with patients with personality disorder.
- 8 sites had low confidence in their abilities to refer to other agencies to obtain social resources for personality disordered service users and their family/carers.
- 9 sites had low confidence in their abilities to advocate on behalf of social networks of people with personality disorder and their carers.
- 7 sites had low confidence in their abilities to develop and deliver therapeutic interventions aimed at improving and sustaining service user's coping skills.
- Clinical Psychologists expressed greater confident in their:
    - Abilities to provide support and supervision for specialist staff and non specialist staff alike.
    - Abilities to apply concepts of boundary maintenance to interactions with individuals.
    - Abilities to support reflective practice for individuals and teams.

Improving Psychological well-being in Personality Disordered Clients

- 7 sites had low confidence in their abilities to apply case formulation based on a range of evidence-based models
- 7 sites had low confidence in their abilities to apply a range of evidence-based interventions for personality disorder
- 7 sites had low confident in their abilities to collaborate with multidisciplinary colleagues and services to provide integrated care.
- Psychiatric Services were reasonably confident in their abilities to:
    - Assess co-morbid factors in personality disorder
    - Clinically assess personality disorder and create an informative care plan
    - Tolerate frustration and anxiety in their work.
- Clinical Psychologists were reasonably confident in their abilities to:
    - Understand symptoms of personality disorder, and its implication on social functioning
    - Assess co-morbid factors in personality disorder
    - To apply case formulation based on a range of evidence-based models

Assessing and Managing Risk to Others in Personality Disordered Clients

- 6 services lacked confidence in their abilities to assess and interpret risks and needs.
- 8 sites lacked confidence in their ability to conduct a family and community risk and needs assessment.
- Services were reasonably confident in their abilities to:
    - Plan and deliver interventions based on case formulation and address specific risk factors.
    - Apply an understanding of the legal and ethical issues in the contest of risk assessment and management.
    - Devise and collaborate with multidisciplinary risk management plans.

9.4 The Social Services Survey

Response 11/46 (23.9%)

Services

- 10 (90%) social services included people with personality disorder within their remit.
- 9 (81%) respondents did not consider the diagnosis of personality disorder as part of their remit, and indicated that was usually done by a multidisciplinary mental health team.
- None of the respondents were familiar with the current preferred structured assessments of personality disorder.
- 9 (81%) services were willing to accept people with a primary or secondary diagnosis of personality disorder, including antisocial personality disorder, or personality disorders associated with a risk of violence to others. 2 were not.
- Such services were provided in the absence of ring fenced money in all cases. Respondents gave several examples of current gaps in services for personality disordered service users which required development.

Assessment of Risk and Needs in Personality Disorder

- 10 (90%) social services regularly conducted risk assessments for service users with diagnosis of personality disorder.
- 8 (73%) regularly conducted needs assessments for service users with diagnosis of personality disorder.
- Both risk and needs assessment were carried out by a multidisciplinary team in 10 cases (90%).
- 6 social services used comprehensive methods to collate information for a risk and needs assessment and the development of a management strategy.
- Only 3 (27%) services were familiar with the use of structured clinical assessments in risk and needs management.
- 9 (81%) services were routinely formulating risk management plans on the basis of current assessment techniques.
- In terms of monitoring risk management, there was considerable evidence of multidisciplinary working across Scotland with Social Workers and key workers (roles may be inter-changeable) indicating significant responsibilities.
- 10 social services use the Care Programme Approach where indicated with clients with personality disorder.
- 5 (45%) routinely use Integrated Care Pathways with clients with personality disorder.

Therapeutic/Clinical Management Services for Clients with Personality Disorder

Table 10 outlines the services currently available to patients with a diagnosis of personality disorder throughout Scotland.

Table 10 Services currently available to clients with personality disorder

Service	Currently available to clients with a diagnosis of a personality disorder
Services:	
Social Work	8
Housing Support	8
Occupational Therapy	8
Nursing	5
Psychiatry	5
Psychology	5
‘Untrained’ support workers	6
Drop-in facilities	6
Client Advocacy	7
Specific Interventions:	
Drug and Alcohol services	6
Cognitive Behavioural therapy (individual basis)	4
Cognitive Behavioural therapy (group-work basis)	
Psychotherapy (individual)	2

Psychotherapy (group)	
Counselling	3
Dialectical behaviour therapy	1
Therapeutic Community	
Anger Management	4
Relapse Prevention	4
Sex Offending	
Moral Reasoning	
Problem-Solving Training	4
Social Skills Training	6
Activities of daily living	5
Interpersonal relationships	3

- This simplistic service mapping provides rudimentary evidence that there are piecemeal services available to social services users with a diagnosis of personality disorder in Scotland.
- Respondents indicated the same range of service availability but with less frequency than their NHS colleagues. While the majority of services indicated that service users have access to Social Work, Housing, Occupational Therapy and Client Advocacy, and support workers at some level, their access to more specific therapies was not consistent.

Competencies and Training Needs

Promoting Social Functioning in Personality Disordered Clients

- A significant proportion of services lacked confidence in their:
    - Abilities to support staff in maintaining a positive attitude towards working with personality disorder
    - Abilities to develop and deliver therapeutic interventions aimed at improving and sustaining service user's coping skills.
    - Abilities to apply boundary maintenance
- Respondents were more confident in their Organisation's abilities to:
    - Contribute to the development of positive strategies for challenging stigma and promoting social inclusion in partnership with service users
- In comparison to their NHS colleagues, Social Services respondents appeared to show a higher level of confidence in their :
    - Abilities to refer to other agencies to obtain social resources for personality disordered service users and their family/carers.
    - Abilities to advocate on behalf of social networks of people with personality disorder and their carers
    - Abilities to provide support and supervision for specialist staff and non specialist staff alike
    - Abilities to support reflective practice for individuals and teams.

Improving Psychological well-being in personality disordered Clients

- A significant proportion of services lacked confidence in their abilities to:
  - Apply a critical understanding to theories of personality disorder and consider the reliability and validity of the diagnoses.
  - Understand the symptoms, and implications on social functioning.
  - Clinically assess personality disorder and use to create an informative care plan
  - Apply case formulation based on a range of evidence-based models
  - Assess co-morbid factors in personality disorder
  - Apply a range of evidence-based interventions for personality disorder
- Services felt reasonably competent in their abilities to:
  - Collaborate with multidisciplinary colleagues and services to provide integrated care
  - Tolerate frustration and anxiety in their work.

Assessing and Managing Risk to Others in Personality Disordered Clients

- A significant proportion of services lacked confidence in their abilities to:
  - Apply structured clinical and actuarial risk assessments (to be expected)
  - Understand and promote a dynamic risk and needs assessment paying particular needs to cognitive and interpersonal factors, substance misuse
  - Devise multidisciplinary risk plans.
- Services felt reasonably competent in their abilities to:
  - Collaborate with multidisciplinary risk management plans.
  - Engage in reflective practice on risk and needs assessment

9.5 Conclusions

Forensic Mental Health Services should develop a philosophy of care or stated service principles for people with forensic personality disorder (recommendation 1).

Greater consistency is required in the assessment of people with forensic personality disorder (recommendations 5-7).

Data collection systems should be improved to provide accurate information regarding forensic personality disorder on which to base service planning (recommendation 4).

There are no specific services for people with forensic personality disorder. Services can be accessed through mental health or social services but these tend to be piecemeal. The Working Group recommends the following to encourage staff engagement with this group and to improve mental health services available to them:

- **A formal system for criminal justice social workers to request forensic mental health assessments should be established. This should be offered as a pilot service in one or more area to assess workload and resource**

requirements. These pilots should develop clear referral criteria and an assessment battery. Such criteria are likely to focus on problem behaviours rather than a specific diagnosis. Additional resources will be required for the pilots. Any pilot must be evaluated. The pilots should offer an assessment service with treatment as usual, and any specific collective treatment and / or training needs should be identified during the pilot for further service planning (recommendation 13).
It is recognised that assessment and care management social services are provided, where appropriate, by generic social work staff or social workers within (forensic) community mental health teams, often at the point when any statutory order ends. The pilot evaluation should consider the need to widen the criminal justice social work remit or the need to ensure the establishment of social workers within community forensic services.

- **Patients with a primary diagnosis of personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system, are not normally admitted on a compulsory basis to psychiatric hospital. At present no change is recommended to current clinical practice in Scotland (recommendation 15).**

- **Recognition should be given to the problem of personality disorder as a co-morbid diagnosis, and assessment and management protocols made available in all forensic mental health settings accordingly (recommendation 17).**

- **It is recognised that there is a small cohort of patients in special security psychiatric care in Scotland that have a primary diagnosis of personality disorder. Whilst some of these cases are historical there is evidence to suggest that there may be a small number of patients added to this cohort because of a change in diagnosis. The following are therefore advised to avoid further cases (recommendation 18):**

    - **A recommendation of an interim hospital order or interim compulsion order to court as standard practice to prolong the period of assessment.**
    - **A recommendation of a hospital direction to court in cases where personality disorder may be the prominent issue in future risk to public safety and the link between the major mental illness / learning disability and the offending behaviour is not clear.**
    - **An automatic review of all patients detained under a transfer direction or transfer for treatment direction in forensic mental health inpatient units before being considered for ongoing civil detention after the expiry of their prison sentence. Local arrangements should be put in place for such reviews.**
    - **The development of similar options for the courts in Northern Ireland.**

A service should continue to be developed for the small group of patients with a primary diagnosis of personality disorder currently in the State Hospital whose discharge is prevented under the provisions of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 (recommendation 19) .

The rehabilitation of these patients outwith the State Hospital is problematic. The development of a specialist team (psychiatry, psychology, nursing, social work, occupational therapy) for the resettlement of patients with a primary diagnosis of personality disorder outwith the State Hospital should be considered to provide outreach support to and shared clinical responsibility with the local team in an inpatient or outpatient setting. In combination with the MAPPA style arrangements proposed (12) this may encourage local teams to engage with these patients. These arrangements involve police, criminal justice social workers, prison officers, health professionals and staff from a wide variety of social services in the identification, assessment and management of people with forensic personality disorder (recommendation 20).

The Forensic Network should ask the Scottish Executive for a view on the referral of cases to the Scottish Criminal Cases Review Commission, where the Responsible Medical Officer considers that the primary diagnosis is one of personality disorder but evidence was given in court at the time of the trial and / or disposal regarding a primary diagnosis of a different mental disorder (recommendation 21).

One or more pilot prison and mental health team should be identified to carry out detailed assessments of problematic prisoners, and to develop management plans in conjunction with the prison's Risk Management Group. These pilots should develop clear referral criteria, an assessment battery, and an agreed management strategy tailored to each individual. Additional resources will be required. Any pilot must be evaluated (recommendation 26).

Specific competency and training needs were identified by the survey.

- **Training and supervision will be essential in any setting for the successful engagement of staff with individuals with personality disorder. This will require:**

  A change of culture
  The development of a competency framework for practice
  The development and use of robust risk management procedures
  Specific training programmes should be created for the pilots recommended (recommendations 13 and 26) and for the further development of services at the State Hospital (recommendations 17-21). The training programmes should subsequently be rolled out to all forensic mental health settings in Scotland (recommendation 30).

- **All individuals acting as key workers or carrying out interventions with people who have a personality disorder should receive 1 hour of clinical supervision per week, from a suitably experienced professional (recommendation 31).**

10. RESOURCES

Significant sums of money are being spent on pilot forensic personality disorder developments in England and Wales (see section 4 and appendix B). An indication of these costs is presented below. Some of the recommendations contained in this report, for example on pilot services for people with personality disorder in prison or on a referral service for criminal justice social work, require liaison and planning with a willing local service on the format of these developments. For this reason it is not possible to give estimated costs of the proposals.

10.1 Forensic Mental Health Service Personality Disorder Sample Pilots

10.1.1 Newcastle, North Tyneside and Northumberland Mental Health NHS Trust: Revenue Budget (at 03/04 costs)

Community Personality Disorder team - £340k/year
Maximum of 30 outpatients
Includes:
£290k staff costs (7.5 whole time equivalent staff)
£50k non-staff costs
£94k Indirect costs/overheads/capital charge etc
Total cost £434k

Inpatient Personality Disorder team - £2.02 million
10 inpatients
Includes:
£1.9m staff costs (62.5 wte)
£122k non staff costs
£606k Indirect costs/overheads/capital charge etc
Total cost £2.65m (approx)

10.1.2 Dangerous and Severe Personality Disorder

£185,000/yr per DSPD place in Rampton High Security Hospital
£85,000/yr per DSPD place in prison (normal prison place cost £35,000/yr)

10.1.3 General Psychiatry

11 community focussed pilots in general psychiatry £10.9 million
Primary care £8 million
NIMHE for training £2 million
National Personality Disorder Team – to evaluate pilots
3 inpatients services (therapeutic communities) – commissioned nationally

10.2 Conclusion

The development of services for the assessment and management of individuals with forensic personality disorder will require resources. The various recommendations, if accepted, will require implementation plans including detailed financial plans (recommendation 33).

11. PREVENTION

There is a literature on the prevention of development of personality disorder, in particular antisocial personality disorder (e.g. Harrington and Bailey, 2003). The opportunity for prevention has largely passed by the time individuals with personality disorder(s) who present a significant risk of physical and psychological harm to others and who come into contact with the criminal justice system or are likely to come into contact with the criminal justice system, are interacting with staff related to the Forensic Network. However, such staff possess expertise in the causation, assessment and management of personality disorder, and should make this readily available to child and adolescent psychiatric services, social services and youth criminal justice services.

11.1 Conclusions

Adult forensic mental health services should make their expertise in the causation, assessment and management of personality disorder readily available to child and adolescent psychiatric services, social services and youth criminal justice services, to assist in the development of programmes designed to prevent the development of antisocial personality disorder (recommendation 34).

The Forensic Network should, in conjunction with appropriate child and adolescent psychiatric services, develop forensic child and adolescent forensic mental health services (recommendation 35).

12. RECOMENDATIONS

General

12.1 Personality Disorder should not be a diagnosis of exclusion from forensic mental health services in Scotland. Forensic Mental Health Services should develop a philosophy of care or stated service principles for people with forensic personality disorder.

12.2 Services for people with personality disorders are required given the frequency with which they are found in the criminal justice and mental health systems in Scotland.

12.3 The Forensic Network should track any proposals arising from the work of the Centre for Change and Innovation and the Scottish Executive in the assessment and management of people with personality disorder in other fields of mental health throughout Scotland.

12.4 Data collection systems should be improved to provide accurate information on forensic personality disorder for service planning.

Assessment of People with Personality Disorder

The following practice is recommended for the assessment of people with a suspected personality disorder. It is recognized that the ideal standard will not be attainable at all consultations and will require modification accordingly. It should be attainable in all forensic mental health inpatient settings.

12.5 A diagnosis of personality disorder (primary or secondary) should be considered during all forensic mental health consultations.

12.6 The assessment of personality disorder should ideally be multidisciplinary and include:

- an emphasis on third party information
- assessment for the presence of axis I disorders
- use of standardized measures of personality disorder
- assessment of risk of harm to others using standardized measures
- a formulation of symptoms and behaviours associated with the personality disorder

12.7 Suggested assessment measures include:

- Personality Disorder - Clinical assessment based on ICD-10 or DSM-IV criteria
  - International Personality Disorder Examination
  - Psychopathy Checklist-Revised or Screening Version
- Mental Illness - Clinical ICD-10
- Risk of Violence - Historical Clinical Risk 20
- Risk of Sexual Offending - Risk of Sexual Violence Protocol; Risk Matrix 2000

Management of People Personality Disorder

12.8 The evidence base for the treatment of personality disorder is not strong. There is some evidence of the efficacy of structured coherent psychological approaches for people with personality disorder but the use of these and of medication for the treatment of specific symptoms is under researched. In addition, such approaches require further assessment of their effectiveness in people with a forensic personality disorder.

12.9 Any interventions should be developed in line with the evidence based ten Home Office accreditation criteria for offending behaviour programmes and should:

- have a clear model of change (i.e. a theoretical underpinning to the programme, based on a model of personality development and disorder)
- have a clear criteria for patient selection
- target relevant dynamic risk factors
- use effective methods
- teach skills that will assist patients to avoid offending and pursue legitimate pursuits
- have a clear description of the sequencing, intensity and duration of the different components of the programme
- maximise engagement and motivation
- ensure continuity with other programmes/services
- monitor its performance
- undertake a long term-evaluation

12.10 Services developed for people with personality disorders should adopt a problem behaviour focus arising from a case formulation and address a range of interventions that target the factors that underlie risk related behaviour.

12.11 These services require to be developed within a range of environments including the community, hospital and prison.

Community

12.12 The Risk Management Authority should be given the powers to develop arrangements similar to those provided by Multi Agency Public Protection Panels in England and Wales to encourage the involvement of health and social services staff in the assessment and management of individuals with forensic personality disorder in the community by the development of a system of information sharing, responsibility sharing, risk assessment and risk management. To successfully engage staff in working with people with forensic personality disorder, and thereby increase the likelihood of improved public safety, it is essential that a culture of information exchange and shared responsibility is developed, and that a blame culture is avoided.

12.13 A formal system for criminal justice social workers to request forensic mental health assessments should be established. This should be offered as a pilot service in one or more area to assess workload and resource requirements. These pilots should develop clear referral criteria and an assessment battery. Such criteria are likely to focus on problem behaviours rather than a specific diagnosis. Additional resources will be required for the pilots. Any pilot must be evaluated. The pilots should offer an assessment service with treatment as usual, and any specific collective treatment and / or training needs should be identified during the pilot for further service planning.

12.14 The Forensic Network should monitor the outcome of the pilot community services currently being established in England and Wales.

Inpatient Services

12.15 Patients with a primary diagnosis of personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system, are not normally admitted on a compulsory basis to psychiatric hospital. At present no change is recommended to current clinical practice in Scotland.

12.16 The Forensic Network should monitor the outcome of the pilot inpatient services for people with a personality disorder and DSPD units currently being established in England and Wales before considering any change to current clinical practice. Any future developments of inpatient units for people with a primary diagnosis of personality disorder in Scotland must include clearly defined routes to lower security and to the community.

12.17 Recognition should be given to the problem of personality disorder as a co-morbid diagnosis, and assessment and management protocols made available in all forensic mental health settings accordingly.

12.18 It is recognised that there is a small cohort of patients in special security psychiatric care in Scotland that have a primary diagnosis of personality

disorder. Whilst some of these cases are historical there is evidence to suggest that there may be a small number of patients added to this cohort because of a change in diagnosis. The following are therefore advised to avoid further cases:

- A recommendation of an interim hospital order or interim compulsion order to court as standard practice to prolong the period of assessment.
- A recommendation of a hospital direction to court in cases where personality disorder may be the prominent issue in future risk to public safety and the link between the major mental illness / learning disability and the offending behaviour is not clear.
- An automatic review of all patients detained under a transfer direction or transfer for treatment direction in forensic mental health inpatient units before being considered for ongoing civil detention after the expiry of their prison sentence. Local arrangements should be put in place for such reviews.
- The development of similar options for the courts in Northern Ireland.

12.19 A service should continue to be developed for the small group of patients with a primary diagnosis of personality disorder currently in the State Hospital whose discharge is prevented under the provisions of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 .

12.20 The rehabilitation of these patients outwith the State Hospital is problematic. The development of a specialist team (psychiatry, psychology, nursing, social work, and occupational therapy) for the resettlement of patients with a primary diagnosis of personality disorder outwith the State Hospital should be considered to provide outreach support to and shared clinical responsibility with the local team in an inpatient or outpatient setting. In combination with the MAPPA style arrangements proposed (12) this may encourage local teams to engage with these patients. These arrangements involve police, criminal justice social workers, prison officers, health professionals and staff from a wide variety of social services in the identification, assessment and management of people with forensic personality disorder.

12.21 The Forensic Network should ask the Scottish Executive for a view on the referral of cases to the Scottish Criminal Cases Review Commission, where the Responsible Medical Officer considers that the primary diagnosis is one of personality disorder but evidence was given in court at the time of the trial and / or disposal regarding a primary diagnosis of a different mental disorder

Prison

12.22 The group supported the focus of the Scottish Prison Service during the initial sentence management process on identifying problems and needs rather than diagnosis. There is a comprehensive assessment process for identifying risk and needs and there is a structure in place to deal with those identified as high risk or problematic through the Risk Management Groups.

12.23 The group recognised that the issue of personality disorder is central to many problem behaviours found in prisons, to failure to engage with therapeutic programmes and to an excessive drain on health service resources within prison by continual demands for assessment and medication. The group therefore recommended that in these contexts assessment of individuals for the presence of personality disorder would assist in their subsequent management.

12.24 The group identified a need to strengthen mental health teams within prisons. All prisons should have a multidisciplinary health team of a standard set out in the policy document "Positive Mental Health" (Scottish Prison Service, 2002). At the present time these are focussed entirely on the identification and treatment of those with mental illness, and struggle to fulfil this role. In addition, they are rarely truly multidisciplinary.

12.25 The group identified a need for visiting mental health professionals to engage more widely with the therapeutic work of the prison service, including offender based programmes.

12.26 One or more pilot prison and mental health team should be identified to carry out detailed assessments of problematic prisoners, and to develop management plans in conjunction with the prison's Risk Management Group. These pilots should develop clear referral criteria, an assessment battery, and an agreed management strategy tailored to each individual. Additional resources will be required. Any pilot must be evaluated.

12.27 Staff training and supervision will be required to work with people with personality disorder in prison. This will be required on two levels: firstly, for staff to assess and manage these individuals; and secondly, for staff carrying out specific programmes which may contain these individuals within the prison.

12.28 There is evidence from HMP Grendon that prisons or special units run on the principles of a therapeutic community can improve aggressive behaviour within that setting. It is recognised that these units require strong leadership and a clear psychotherapeutic principle basis to succeed and that focus may be lost over time. The group recommends that the Forensic Network examines the evidence, as it becomes available, from the DSPD units in England and findings from the Scottish prison pilot recommended above (26) before making any recommendation on re-establishing such units within the Scottish Prison Service.

12.29 The Group acknowledged the day programme approach developed in HMP Barlinnie (Open Doors Programme) and HMP Perth for vulnerable prisoners or prisoners with major mental illness. To succeed, any such day programmes must have a defined client group and therapeutic focus, and access to multidisciplinary input. The group recommends that the Forensic Network examines the evidence, as it becomes available, from the Scottish prison pilot recommended above (26) before making any recommendation on establishing day programmes for people with personality disorder within the Scottish Prison Service.

Training and Supervision

12.30 Training and supervision will be essential in any setting for the successful engagement of staff with individuals with personality disorder. This will require:

- A change of culture
- The development of a competency framework for practice
- The development and use of robust risk management procedures

Specific training programmes should be created for the pilots recommended above (13 and 26) and at the State Hospital (18-21). The training programmes should subsequently be rolled out to all forensic mental health settings in Scotland.

12.31 All individuals acting as key workers or carrying out interventions with people who have a personality disorder should receive 1 hour of clinical supervision per week, from a suitably experienced professional.

Specific Considerations

12.32 The Forensic Network should ask the chairs and nominated members of the working groups on women and learning disability to consider the particular issue of personality disorder for their respective cohorts in light of the recommendations contained in this report.

Resources

12.33 The development of services for the assessment and management of individuals with forensic personality disorder will require resources. The various recommendations, if accepted, will require implementation plans including detailed financial plans.

Prevention

12.34 Adult forensic mental health services should make their expertise in the causation, assessment and management of personality disorder readily available to child and adolescent psychiatric services, social services and youth criminal justice services, to assist in the development of programmes designed to prevent the development of antisocial personality disorder.

12.35 The Forensic Network should, in conjunction with appropriate child and adolescent psychiatric services, develop forensic child and adolescent forensic mental health services.

13. REFERENCES

American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders: text revision. American Psychiatric Association, Washington, D.C.

American Psychiatric Association (2001) Practice Guidelines for the Treatment of Patients with Borderline Personality Disorder, American Psychiatric Association, Arlington, USA.

Andrews, D.A. and Bonta, J. (1995) The level of service inventory - revised manual. Multi-Health Systems Inc, Toronto.

Baron, M. (1981) Schedule for Interviewing Borderlines. New York State Psychiatric Unit. New York

Baron, M., Asnis, L. and Gruen, R. (1981) The schedule for Schizotypal Personalities (SSP): a diagnostic interview for schizotypal features. Psychiatry Research 4(2):213-28.

Bartlett, K.L.H., Thomson, L.D.G. and Johnstone, E.C. (2001) Mentally Disordered Offenders: an evaluation of the "Open Doors" Programme at H.M. Prison, Barlinnie, Scottish Prison Service, Occasional Paper Series No. 2/2001.

Bateman & Fonagy (1999) Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. American Journal of Psychiatry, 156, 1563-1569.

Bateman, A. and Tyrer, P. (2004a) Psychological Treatment for Personality Disorders, Advances in Psychiatric Treatment, 10, 378-388.

Bateman, A., and Tyrer, P. (2004b) Services for Personality Disorder: Organisation for Inclusion, Advances in Psychiatric Treatment, 10, 425-433.

Blackburn, R., Logan, C., Donnelly, J. and Renwick, S. (2003) Personality Disorders, Psychopathy and other Mental Disorders: Comorbidity among patients at English and Scottish high security hospitals, The Journal of Forensic Psychiatry and Psychology, 14(1), 111-137.

Boer, D.P., Hart, S.D., Kropp, P.R., Webster, C.D. (1997) Sexual Violence Risk-20 (SVR-20), Professional Guidelines for Assessing Violence. The Mental Health, Law and Policy Institute, Simon Fraser University, Vancouver.

Casey, P.R. and Tyrer, P. (1990) Personality Disorder and Psychiatric Illness in General Practice, British Journal of Psychiatry, 156, 261-265.

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

Chiswick, D. (1992) Compulsory Treatment of Patients with Psychopathic Disorder: An abnormally aggressive or seriously irresponsible exercise? Criminal Behaviour and Mental Health, 2, 106-113.

Cleckley, H. (1941) The Mask of Sanity, London: Henry Klimpton.
Coid, J. W. (2003). Epidemiology, public health and the problem of personality disorder. British Journal of Psychiatry, 182, 3-10.

Coid, J.W. (2002) Personality Disorders in Prisoners and their Motivation for Dangerous and Disruptive Behaviour, Criminal Behaviour and Mental Health, 12, 209-226.

Cooke, D. and Michie, C. (1999) Psychopathy Across Cultures: North America and Scotland Compared, Journal of Abnormal Psychology, 108(1), 58-68.

Cooke, D.J., Michie, C., Ryan, J. (2001) Evaluating risk for violence: a preliminary study of the HCR-20, PCC-R and VRAG in a Scottish prison sample. Scottish Prison Service.

Copas, J.B., Marshall P. (1998) The offender group reconviction scale: a statistical reconviction score for use by probation officers. Applied Statistics 47(1): 159-171.

Copas, J.B., Marshall, P., Tarling, R. (1996) Predicting reoffending for discretionary conditional release, Home Office, London.

Darjee, R. and Crichton J. (2003) Personality Disorder in the Law in Scotland: a historical perspective, The Journal of Forensic Psychiatry Psychology, 14(2), 394-425.

De Girolamo, G. and Dotto, P. (2000) Epidemiology of Personality Disorders: A New Oxford Textbook of Psychiatry, Vol. 1, M J Gelder, J J Lopez-Ibor, and M C Andraessen, eds, Oxford University Press, New York, 959-964.

Feighner, J.P., Robins, E., Guze, S.B., Woodruff, R.A., Winokur, G. and Munoz, R. (1972) Diagnositic criteria for use in psychiatric research. Archives of General Psychiatry 26:57-63

First, M.B., Spitzer, R.L., Gibbon, M. and Williams, J.B.W. (1995) The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II) Part I: Description. Journal of Personality Disorders, 9, 83-91.

Gunn J (1992) Personality disorders and forensic psychiatry. Criminal Behaviour and Mental Health 2 202-211

Hanson, R.K. (1997) The development of a brief actuarial risk scale for sexual offence recidivism (User Report 97-04). Department of the Solicitor General of Canada, Ottawa.

Hanson, R.K. and Harris, A.J.R. (2001) A structured approach to evaluating change among sexual offenders. Sexual Abuse: a journal of research and treatment 13(2):105-122.

Hanson, R.K. and Thornton, D. (2000) Improving risk assessments for sex offenders: a comparison of three actuarial scales. Law and Human Behaviour, 24(1): 119-136.

Hare, R.D. (1991) The Hare Psychopathy Checklist-Revised. Multi-Health Systems. Toronto

Harrington, R., and Bailey, S. (2003) The Scope for Preventing Antisocial Personality Disorder by Intervening in Adolescence, National Research and Development Programme in Forensic Mental Health Report. Liverpool.

Hart, S.D., Kropp, P.R., Laws, D.R., Klaver, J. & Watt, K.A. (2003) The Risk for Sexual Violence Protocol (RSVP). Burnaby, BC: Simon Fraser University, Mental Health, Law and Policy Institute.

Hobson, J. and Shine, J. (1998) Measurement of Psychopathy in a UK Prison Population Referred for Long-term Psychotherapy, British Journal of Criminology, 38(3), 504-515.

Home Office (2002) Offender Assessment System (OASys). www.crimereduction.gov.uk Accessed on 27 May 2005

Home Office (2003) Multi-Agency Public Protection Arrangements Guidance. Crown Copyright 2004. London

Home Office (2004) Dangerous and Severe Personality Disorder (DSPD) High Secure Services, Planning and Delivery Guide, Home Office, HM Prison Service and Department of Health, London.

Jones, D. (2004) Working with Dangerous People: the psychotherapy of violence, Radcliffe Medical Press Ltd: Abdingdon: UK. ISBN 1 85775 824 2.

Klein, M.H., Benjamin, L.S., Rosenfeld, R. et al. (1993) The Wisconsin Personality Disorders Interview: development, reliability and validity, Journal of Personality Disorders, 7, 285-303.

Kropp, P.R., Hart, S.D., (2000) The spousal assault risk assessment (SARA) guide: reliability and validity in adult male offenders. Law and Human Behaviour 24(1): 101-118.

Leichsenring, F. and Leibing, E. (2003) The effectiveness of psychodynamic therapy and cognitive behaviour therapy in the treatment of personality disorders: A meta-analysis . American Journal of Psychiatry, 160, 1223-1232.

Linehan M.M., Armstrong H.E., Suarez A., Allmon D., Heard H.L. (1991) Cognitive behavioural treatment for chronically parasuicidal borderline patients. Archives of General Psychiatry, 48, 1060-1064.

Lipton, D.S., Pearson, F.S., Cleland, C.M. and Yee, D. (2002) The effectiveness of cognitive behavioural treatment methods on offender recidivism. Meta-analytic outcomes from the SDATE project. In J. McGuire (Ed.), Offender rehabilitation and treatment. John Wiley, Chichester.

Loranger, A.W., Sartorius, N., Andreoli, A., et al. (1994) The International Personality Disorder Examination: the SHO/ADAMHA international pilot study of personality disorders, Archives of General Psychiatry, 51, 215-224.

Mann, A.H., Jenkins, R., Cutting, J.C. and Cowen, P.J. (1981) The development and use of a standardized assessment of abnormal personality, Psychological Medicine, 11, 839-847.

McGuire, J. (1995) What works: reducing offending – guidelines from research and practice. Wiley. Chichester, New York

McMurran, M. (2003) Expert Paper: Personality Disorders. NHS National Programme on Forensic Mental Health Research and Development, Liverpool.

Millon, T., Davis, R. and Millon, C. (1997) MCMI-III manual. National Computer Systems, Minneapolis.

Monahan, J., Steadman, H.J., Silver, E. et al. (2001) Rethinking risk assessment. The MacArthur study of mental disorder and violence, Oxford University Press, New York.

Moran, P. (1999) Antisocial Personality Disorder: A epidemiological perspective, Royal College of Psychiatrists, Gaskell, ISBN 0-901242-24-2.

Munroe-Blum, H. and Marziali, E. (1995) A controlled trial of short-term group treatment of borderline personality disorder. Journal of Personality Disorder, 9, 190-198.

NIMHE (2003a) Personality Disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder. National Institute for Mental Health in England, Gateway ref. 1055, London.

NIMHE (2003b) Breaking the Cycle of Rejection. The Personality Disorder capabilities Framework. National Institute for Mental Health in England, Gateway ref. 1055, London.

Perry, J. (1982) The Borderline Personality Disorder Scale (BPD-Scale). Cambridge Hospital. Cambridge, Mass

Pfohl, B., Blum, N. and Zimmermann, M. (1995) Structured interview for DSM-IV personality: SIDP-IV. Department of Psychiatry, University of Iowa.

Pilkonis, O.A., Blehar, M.C., & Prich, R. F (1997). Research directions for the personality disorders, Part 1. Journal of Personality Disorders, 11, 201-204.

Quinsey,V.L., Harris, G.T., Rice, M.E., and Cormier, C.A. (1998) Violent offenders, appraising and managing risk. American Psychological Association, Washington, DC.

Gunn, J. (1992) Personality Disorders in Forensic Psychiatry, Criminal Behaviour and Mental Health, 2, 202-211.

Robins, L., Helzer, J. Croughan, J., et al. (1979) The National Institute of mental health Diagnostic Interview Schedule. NIMH. Rockville, Md

Roth, A. (2005) What works for whom? A critical review of psychotherapy research. Guilford Press. New York

Royal College of Psychiatrists (1999) Offenders with Personality Disorder, Gaskell. London

Salekin, R.T. (2002) Psychopathy and therapeutic pessimism. Clinical Psychology Review, 22, 79-112.

Scottish Executive (2001) Reducing the Risk – Improving the Response to Sex Offending: Cosgrave Report, Edinburgh.

Scottish Executive (2001) Serious, Violent and Sexual Offenders: The MacLean Committee Report, Edinburgh.

Scottish Executive (2001) Services, Care, Support and Accommodation for Mentally Disordered Offenders in Scotland: Care Pathway Document, Health Department, NHSHDL(2001), 9, St Andrew's House, Edinburgh. ISBN 1-84268-939-8.

Scottish Office (1999) Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland, MEL (5), Edinburgh.

Scottish Prison Service (2002) Positive Mental Health, Edinburgh.

Semple, D., Smyth, R., Burns, J., Darjee, R., and McIntosh, A. (2005) Oxford Handbook of Psychiatry, Oxford, Oxford University Press.

Shine, J. (2000) HMP Grendon: A Compilation of Grendon Research, Printed by PES at HMP Leyhill, 1/2000 XLY H 659.

Singleton, N. Meltzer, H. Gatward, R. (1998) Psychiatric Morbidity Among Prisoners in England and Wales. The Office for National Statistics. The Stationery Office, London.

Social Work Services Inspectorate (2000) Management and assessment of risk in social work services. Scottish Executive, Edinburgh.

Special Hospitals Service Authority (1995) Patient population of special hospitals by Mental Health Act 1983 classification and gender, 1986-1994. In Moran, P. Antisocial Personality Disorder – an epidemiological perspective, Gaskell.

Thomson, L.D.G., Bogue, J., Humphreys, M., Owens, D. and Johnstone, E. (1997) State Hospital Survey: A description of psychiatric patients in conditions of special security in Scotland, The Journal of Forensic Psychiatry, 8(2) 263-284.

Thomson, L.D.G., (2005) Psychiatric Systems and Services for Mentally Disordered Offenders. In Mental Health and Scots Law in Practice, McManus, J.J. and Thomson, L.D.G., Publishers: W. Green & Sons, Edinburgh,

Thornton, D., Mann, R., Webster, S., Blud, L., Travers, R., Friendship, C. and Erickson, M. (2003) Distinguishing and combining risks for sexual and violent recidivism. In R.Prentky, E. Janus and M.Seto (Eds.) Understanding and managing sexually coercive behaviour. Annals of the Academy of Sciences.

Tyrer, P. (2004) Getting to grips with severe personality disorder, Criminal Behaviour and Mental Health, 14, 1-4.

Tyrer, P. and Bateman, A. (2004) Drug Treatment for Personality Disorders, Advances in Psychiatric Treatment, 10, 389-398.

Tyrer, P. and Ferguson, B. (2000) Classifications of personality disorder, In Personality Disorders: diagnosis, management and cause (ed. Tyrer P.) Butterworth Heinemann. Oxford

Tyrer, P., Alexander, J. and Ferguson, B. (1998b) Personality Assessment Schedule (PAS) In Personality Disorders: Diagnosis, management and course, London: Wright, 1988: 93-104.

Verheul, R. (2001) Comorbidity of Personality Disorders in Individuals with Substance Use Disorder, European Psychiatry, 16, 274-282.

Ward T, Laws R, & Hudson SM (2002) Sexual Deviance: Issues and Controversies. Sage. London

Warren, F., McGauley, G., Norton, K., Dolan, B., Preedy-Fayres, K., Pickering, A. and Geddes, J.R. (2003) Review of Treatment for Severe Personality Disorder, Home Office, London.

Webster, C.D., Douglas K.S., Eaves, D. and Hart S., (1997) HCR-20, Historical/Clinical/risk-20, A structure clinical assessment guide, Mental Health, Law and Policy Institute, Simon Fraser University, Vancouver.

Weissman, M.M. (1993). The epidemiology of personality disorders: a 1990 update. Journal of Personality Disorders, **7**, 44-62.

Widiger, T.A.E., & Rogers, J.J. (1989). Prevalence and comorbidity of personality disorders. Psychiatric Annals, 19, 132-136.

Wong, S. and Gordon A. (2000) Violence Risk Scale, Regional Psychiatric Centre. Saskatoon

Woods, P. and Richards, D. (2002) The Effectiveness of Nursing Interventions with Personality Disorders. A systemic review of the literature. School of Nursing, Midwifery and Health Visiting. National Programme on Forensic Mental Health Research. The University of Manchester

World Health Organisation (1992) The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. World Health Organisation, Geneva.

14. APPENDICES

14.1 Appendix A

Working Group Members

Dr. Lindsay Thomson (Chair)	Senior Lecturer in Forensic Psychiatry, The University of Edinburgh; Honorary Consultant Forensic Psychiatrist, The State Hospital
Dr. Edward Duncan (Facilitator)	Clinical Specialist Occupational Therapist The State Hospital; Postdoctoral Research Fellow, The University of Stirling
Dr. Fiona Biggam	Forensic Clinical Psychologist, The State Hospital and Lecturer in Psychology, Glasgow Caledonian University
Dr. Derek Chiswick	Consultant Forensic Psychiatrist & Lead Clinician, The Orchard Clinic, Royal Edinburgh Hospital
Dr Raj Darjee	Lecturer in Forensic Psychiatry, The University of Edinburgh; Specialist Registrar in Forensic Psychiatry, The Orchard Clinic
Prof. Kate Davidson	Consultant Clinical Psychologist, Gartnavel Royal Hospital; Honorary Professor of Clinical Psychology, The University of Glasgow.
Caroline Doyle	Lead Nurse, DSPD Unit, HMP Frankland
Prof. Don Grubin	Professor of Forensic Psychiatry, The University of Newcastle; Honorary Consultant Forensic Psychiatrist
Prof. Roisin Hall	Director of Psychological Services, The Scottish Prison Service.
Annie McGeeney	Social Worker. South Lanarkshire Council
Diane Perera	Registered Mental Nurse, HMP Perth, Scottish Prison Service
Dr Maureen Sturrock	Psychiatric Adviser, Health Department, The Scottish Executive

14.2 Appendix B

Services for people with personality disorders within the criminal justice system and forensic mental health care in England and Wales

The group examined the services for people with personality disorder in England and Wales. In this setting some patients have traditionally been admitted to the high security hospitals for assessment and treatment of a primary diagnosis of personality disorder. The NHS medium secure units have generally followed working patterns more akin to those found in Scotland and have been reluctant to admit this group.

Policy

Personality Disorder: No longer a diagnosis of exclusion (NIMHE, 2003)
This document sets out the policy implementation guidance for the development of services for people with personality disorder in England. It recognises that these services are often neglected or isolated. Importantly the Department of Health are pump priming training, and the development of specialist community, day and inpatient units in both general adult and forensic services. Eight development centres have been established and recommendations were made about:

- General Adult Mental Health Services
- The development of a specialist multidisciplinary personality disorder team to target those with complex problems
- The development of specialist day patient services in areas with high concentrations of morbidity
- Forensic Services
- Staff Selection, Supervision, Education and Training

Multi Agency Public Protection Arrangements (MAPPA)

In England and Wales, the Criminal Justice and Court Services Act (2000) created the Multi Agency Public Protection Arrangements (MAPPA) which require police and probation to work together to manage the risks posed by dangerous offenders in the community (Home Office, 2003). This is being extended to include the prison service. Area Multi Agency Public Protection Panels (MAPPPs) have been created and work under the National MAPPP for operational issues and with the Public Protection Unit on Early Warning System referrals, and on cases whose implications and management extend beyond the relevant area. There is a statutory duty for health, housing, social services, education, social security and employment services, youth offending teams and electronic monitoring providers to cooperate with MAPPPs. MAPPPS have four core functions:

- Identification of MAPPA offenders
- Sharing of relevant information
- Assessment of risk of serious harm
- Management of risk of serious harm

Four features of MAPPA good practice have been identified:

- Defensible decisions
- Rigorous risk assessment

- Delivery of risk management plans that match identified public protection need
- Evaluation of performance to improve delivery.

The guidance clearly recognises that risk can be reduced and managed but not eliminated. MAPPA offers 3 levels of input: level 1 – advice; level 2- multiple agencies involved in the coordination of an individual's care; and level 3 – for high risk cases with need for intensive management and shared responsibility.

Community Forensic Services for People with Personality Disorder

Following the NIMHE 2003 document pilot community forensic services for people with a primary diagnosis of personality disorder have been established. The Committee heard in detail about the service being established in Newcastle.

The core philosophy of the Newcastle Forensic Community Personality Disorder Team (FC PDT) is based on securing inclusive services for people with a diagnosis of Personality Disorder. People are offered the opportunity to establish satisfying lives beyond distress in areas such as relationships, career and independence, by working with individuals, carers, communities and professionals to promote positive change

Inclusion Criteria

- Males age 18 or over
- Primary diagnosis of personality disorder
- From the catchment area covered by the adult forensic service
- History of violent or sexual offending or significant concern about the risk of future violent or sexual offending

Exclusion Criteria

- Primary diagnosis of mental illness
- Primary diagnosis of substance misuse
- IQ under 80 (those with an IQ between 70-79 will be considered on an individual basis)
- Significant organic dysfunction

Methods of Working

As a small team, it is important to ensure that expertise is extended broadly, and that it does not become a service characterised by intensive work with a small group of patients who are shadowed by an increasingly long waiting list. There will, therefore, be greater collaboration with local services and community mental health teams and different tiers of input depending on patient need, with the expectation that the team involvement will in any case be time limited. The levels of input are as follows:

1. Consultation

This might be a one off consultation, or as a case that is reviewed periodically over time, consisting of advice about management following initial assessment and/ or reassurance that the person is being dealt with correctly.

2. Provision of specific treatment
This involves the person continuing to be managed by the local service as above, but being offered a specific type of treatment input from the PD team (for example, anger management, sex offender work, EMDR).

3. Joint working
This will be more relevant in higher risk or more complex situations. Local providers remain responsible for the person's day to day management, but a member or members of the PD team will work closely with them. Some treatment may be provided by the local service, and some by the PD team, either on an individual or group basis.

Consultant responsibility will continue to rest with the local CMHT. Once the individual's risk has been successfully addressed the local service will continue to provide mental health input assuming this remains necessary. Accessing beds will remain the responsibility of local services, as FCPDT do not have access to beds.

Issues of clinical responsibility may give rise to concerns given the high level of actual or potential risk service users may present. All matters regarding risk and risk management will be clarified on an individual basis through joint planning; negotiation and the case plan review process through care coordination.

The extent of the roles and responsibilities FCPDT may be able to take on will to some degree be affected by practicalities such as geographical location but in no case will the FCPDT assume care coordination responsibility for the service user.

Staffing and Patient Numbers

Initially the Newcastle community service will comprise of 6 posts, coming from forensic psychiatric, forensic psychology, forensic mental health nursing, forensic mental health social work, forensic mental health occupational therapy and probation. They will work in interchangeable teams of two, with each individual carrying a caseload of up to 10 cases, which are co-worked.

Treatment

Two co-workers will coordinate outpatient treatment. Treatment modes will include group work, individual psychological therapies and medication. Much of the emphasis will be on case management, with a focus on social types of intervention. The treatment programme will be developed in line with the evidence based ten Home office accreditation criteria for offending behaviour programmes (see page 82).

De-selection
The service is designed to provide treatment for personality disordered individuals for whom there are concerns about risk. However, it is not a containment service, nor can

it guarantee that those with whom it is dealing will not re offend. If a person is too disruptive to respond to treatment or fails to engage with the team in spite of attempts to overcome the difficulties, he will be discharged, in consultation with MAPPP if appropriate.

Inpatient Services for People with Forensic Personality Disorder

The Department of Health is currently funding 5 pilot inpatient secure units for the assessment and treatment of people with forensic personality disorder. In addition, there are also some 7-8 pilot personality disorder services being established within general adult psychiatry.

The details of the Newcastle inpatient personality disorder unit pilot are presented below.

Inclusion Criteria

- Males age 18 or over
- Primary diagnosis of personality disorder (determined by psychiatric/psychological assessment)
- From the geographical area covered by the northern forensic catchment group
- History of violent or sexual offending or significant concern about the risk of violent or sexual offending
- Require and are capable of being managed in a secure setting less than high security

Exclusion Criteria

- Clear evidence of the need for high security (i.e. DSPD)
- Primary diagnosis of mental illness
- Primary diagnosis of substance misuse
- IQ under 80 (those with an IQ between 70-79 will be considered on an individual basis)
- Significant organic dysfunction

Treatment Philosophy – the Therapeutic Environment

The unit will offer a comprehensive treatment programme, which will incorporate a wide selection of needs based individual and group treatments, backed up by activities designed to transfer learned skills from ‘formal’ treatment into a ‘community’ setting. The day will be structured around a formal timetable of activities and groups. The evenings and weekends will be structured around social and recreational activities. There will be a daily community meeting for all staff and patients. All staff and patients will be taught to use a simple problem-solving model, which will be used to deal with issues as they arise. Issues that affect the safety of staff and patients or the harmony of the group will be routinely addressed via the community meetings. House rules will be set with the patient group via the community meetings. When house rules are broken the consequences will be routinely discussed in community meetings. Patients will have regular access to a triumvirate of named primary workers, who will include at least one non-Nurse.

Treatment focus will be directed towards the strengthening of existing adaptive coping mechanisms and developing alternatives to maladaptive (i.e. in terms of personal distress or conflict with society) coping. Patients will be encouraged to take increasing responsibility for their own actions and the consequences of the same.

The focus will be on assisting patients to develop skills that will be required immediately on discharge. It is important to note that the patients' care pathway extends beyond their inpatient admission to hospital and that effective links must be developed and maintained with other agencies that may be involved in the patients' care.

The Treatment Model

The treatment programme will seek to address an individual's clinically identified needs. It will be developed in line with the evidence based ten Home Office accreditation criteria for offending behaviour programmes and will:

- have a clear model of change (i.e. a theoretical underpinning to the programme, based on a model of personality development and disorder)
- have a clear criteria for patient selection
- target relevant dynamic risk factors
- use effective methods
- teach skills that will assist patients to avoid offending and pursue legitimate pursuits
- have a clear description of the sequencing, intensity and duration of the different components of the programme
- maximise engagement and motivation
- ensure continuity with other programmes/services
- monitor its performance
- undertake a long term-evaluation

Treatment success is likely to be measured on either changes in specific areas or ability to manage difficulties more effectively.

The treatment programme will:

- target relevant dynamic risk factors, related to *general* issues i.e. those associated with the nature of the patient's personality disorder and *specific* issues i.e. those associated with offending difficulties.
  Dynamic risk factors are those that are linked to offending (or which reflect core problem areas) which are generally stable over time but can be modified through treatment. These may be *offence specific* (e.g. offence specific interests, distorted thinking specific to offending, weak or fragile commitment to re-offending, empathy deficits, difficulty generating or enacting appropriate coping strategies for personally relevant risk factors, social support for offending) or more *general* (poor cognitive skills, anti-social attitudes or feelings, difficulties with emotional self-regulation, social/interpersonal skills)
- target associated factors that mediate the ability to change or manage the above difficulties (e.g. denial, motivation, locus of control, self-esteem)

- create a therapeutic environment conducive to change
- have clear selection (and de-selection) criteria
- include relevant treatment targets
- use a variety of effective methods
- be skills oriented
- utilise the principles of sequencing, intensity and duration
- be routinely monitored and evaluated by both patients and staff. Criteria may include: symptomatic change, social functioning, quality of life, incidents of societal conflict and informant reports
- have clear continuity of programme and services

Dangerous and Severe Personality Disorder (DSPD)

In England and Wales the concept of dangerous and severe personality disorder has been developed and specific services designed for individuals with DSPD (Home Office, 2004). Four DSPD services exist: two within the prison service (HMP Whitemoor and HMP Frankland – 160 places) and two with the high security hospital service (Broadmoor and Rampton – 140 places).

The working group heard a detailed presentation on the DSPD Unit in HMP Frankland although the need for consistency across all four units was stressed. The Frankland service is driven by psychology, with input from various other disciplines (including psychiatrists, nurses, occupational therapists, probation staff and prison officers). The majority of referrals are received from special hospitals. The following is taken from written materials from HMP Frankland.

Theoretical underpinning

The two major aims of treatment at Frankland's DSPD unit are to enhance the life skills and values of offenders and to reduce the risk they pose to the public. The treatment models are based on specific treatment programmes, as well as pro-social modelling and complimentary regime activities.

Assessment of DSPD

The DSPD Planning and Delivery Guide provides an outline of its assessments and assessment criteria. It is acknowledged that whilst the different DSPD units may have varying approaches to assessment, the essential core elements should remain the same as described below. Assessment is viewed as having several functions:-

- To establish if an individual meets the criteria for admission to a DSPD unit;
- To identify any treatment needs and assist in the development of a care plan; and
- To provide a baseline for future evaluation of intervention packages.

A combination of both actuarial and dynamic risk assessments is used in order to develop and inform a structured clinical judgement. The tools used are listed in Table 6? below.

Table 6 Risk Assessment Tools used in DSPD

Risk Assessment Tools
Violence
VRS
HCR-20
Sexual Offending
Risk matrix 2000
Static 99
SARN
Personality Disorder
PCL-(R)/PCL- (SV)
IPDE
Mental Illness
SC1D-1

Other tools may be used at the discretion of each unit to augment the core assessment process. Moreover, where there is compelling clinical evidence, an individual may be admitted even if they do not meet the admission criteria on the basis of the assessment protocol alone. However, this is viewed as an exceptional measure and clear reasons for its use must be clearly documented in each case.

The following assessments are used across each of the four DSPD sites:-

- Sexual Offending – Risk Matrix 2000; Static 99; SARN
- Personality Disorder – PCL (R) / PCL (SV) / IPDE
- Mental Illness – SCID I
- Violence – VRS; HCR 20

For the purpose of DSPD assessments the criteria for *severe personality disorder* will be deemed as met if an individual:-

- Has a PCL –(R) score of 30 or above (or the PCL-SV equivalent) or;
- PCL-R score of 25-29 (or the PCL-SV equivalent) plus at least one DSM IV personality diagnosis other than ASPD; or
- Two or more DSM IV personality disorder diagnoses

Treatment

The model of treatment varies in the different DSPD units and one is presented as an example. In HMP Frankland, treatment has been based around Tony Ward's (2002) Good Life Model (GLM). The model is derived from traditional relapse prevention models based around addiction. Briefly the GLM of offender rehabilitation is essentially a strength-based approach and as such, seeks to give offenders the capabilities to secure primary human goods (e.g. health, knowledge, play, work, friendship etc.) in socially acceptable ways. These goods, if secured, result in high levels of well-being, and if not achieved, result in lower levels of well-being, which may in turn result in offending. Typically these goods are incorporated in concrete

ways of living, the practices and every day routines that constitute a life. Interventions will focus on installing and/or strengthening the internal and external conditions necessary for an individual to realise his particular GLM, abilities, preferences, and strengths. A strength of the model is that it by virtue of its focus on human goods it provides an avenue to motivate offenders. Therefore the aims and principles of treatment are 'approach focused' and optimistic, rather than simply focusing on risk management and relapse prevention.

The GLM supports the importance of maintaining a twin focus in treatment: promoting welfare and reducing risk. Therefore the major aim of treatment in DSPD is to equip offenders with the necessary internal and external skills required to implement their good lives plan, whilst at the same time addressing any risk factors which act as obstacles that block the acquisition of human goods.

The GLM suggests that the enhancement of offenders' capabilities in order to improve the quality of life may reduce their chances of committing further crimes against the community. By focusing on providing offenders with the necessary conditions (e.g., skills, values, opportunities, social supports etc.) for addressing their needs in more adaptive ways, the assumption is that they will be less likely to be a risk to themselves or to others.

The overarching treatment orientation of Frankland's DSPD programme is cognitive behavioural therapy (CBT). In its most basic form, CBT states that internal thought processes determine a person's response to a given stimulus and that thoughts, feelings and behaviour are interrelated. Cognitive behavioural therapies and the methods they employ are well documented as effective strategies for the treatment of offending behaviour (Andrews et al, 1990; Losel, 1995), and personality disorder (Sperry et al 1999; Beck 1995; Young 1994). The treatment framework will also incorporate strategies taken from Dialectical Behaviour Therapy (DBT). Psychodrama will be also be integrated into treatment in the form of role-play and skills practice.

The phases of treatment loosely incorporate Thornton's (2001) risk domains of Offence Interests, Distorted attitudes, Socio-affective functioning and Self-management. Research has shown that there is a predictive relationship between these domains and recidivism, and therefore these domains must be addressed to achieve a reduction in risk. (Hanson & Harris (2000), Beech et al., (unpublished)). Treatment targets within DSPD will seek to address these risk domains, which are all integrated within the seven phases of treatment.

The phases of treatment are sequential (although prisoner needs will ultimately determine sequence). It aims to: motivate and engage the prisoner within treatment, address the symptoms of PD, modulate the temperament aspect of personality, increase social, occupational and relational functioning, modify the schema dimension of personality, as well as targeting offending behaviour. The first two phases of treatment will be completed during assessment.

The first phase of treatment – Individual Introductory Sessions, has been developed by the Psychopathy team and is to be used with the entire DSPD population. The aims of these sessions include: Introduction to philosophy of the unit, Objectivity training, Identification of personal good life goals and motivators, Identification of gaps,

conflicts, Personal priorities, Barriers to a more fulfilling life, Future Me and Goal Setting.

The second phase of treatment is the 16-week Treatment Needs Analysis, which has been described within the assessment phase.

The third phase of the programme, motivation and engagement, is based upon the principle that without the motivation to change and engagement with treatment, little change is possible. Ward (2002), in his development of his Good Life Model, suggests that increasing an individual's self-esteem, working collaboratively in a warm and empathic way, giving encouragement and praise is more likely to lead an offender to think about change and gain insight into their areas of work. Mann (in press) suggests that motivating offenders and creating a sound therapeutic alliance are pivotal components of effective treatment and should not be viewed as of lesser importance. Ward (2002) advocates that this type of working relationship has a positive effect on motivation and retention in treatment. This phase includes psycho-educational modules in order to increase the individual's awareness of his own personal motivators. Research suggests that if the treatment plan is individualised and consistent with the individual's needs, this breeds a sense of treatment being relevant and an important activity to engage in.

The fourth stage consists of the Self-Management phase, which includes: Flexible Thinking, Critical Reasoning, Interpersonal Skills, Social Skills, Assertiveness, Substance Misuse, Problem Solving and Impulse Control.

The fifth phase incorporates Socio-Affective functioning and includes: Anxiety Management, Anger Management, Empathy, Relationships & Intimacy Skills, Emotion Regulation,

These phases are most useful when preceding any in-depth cognitive work as it is felt that only when a prisoner's temperament is modified, he will have sufficient self-restraint and resources to profit from any further psychotherapies that we can offer on the Westgate Unit. The goal of this sequence is to achieve an adequate degree of social and cognitive competence to ensure prisoners are more prepared for ongoing treatment.

The sixth phase – Attitudes & Beliefs, has been developed to address cognitive distortions, automatic thoughts, core beliefs and schemas. Cognitive strategies will be used to challenge both PD related and Offence related schema. Psychodynamic strategies will also be employed within this phase to focus on personal distress and victimisation issues.

The final stage of treatment will focus on Offence Interests. Specific tools will be used to address sexual and violent offending, arson, domestic violence and acquisitive offences. The tools that will be employed include: life maps, active accounts, decision chains, victim work and cost/gains analysis.

Treatment can be delivered within an individual or group setting. The aim is to provide eight hours of formalised therapy per week, per prisoner. Treatment will be delivered in short bursts of hourly sessions twice a day, three days a week. Remaining

sessions will incorporate regular diary sessions, and group or individual reviews. Treatment will be delivered and supervised by the multidisciplinary team.

Along with these treatment designs, the Westgate Unit will be piloting the Psychopathy Programme for violent psychopathic offenders. The Psychopathy Team at OBPU (Offending Behaviour Programme Unit), are currently developing this programme. Regular consultations occur between the psychopathy team and the Westgate team at HMP Frankland regarding the practicalities of piloting this programme.

Overall aims of treatment are realistic and do not expect to eradicate personality disorder, but instead aim to increase the prisoners' functioning and capabilities needed to live his life differently.

Evaluation

Pre and post measures for each structured treatment group
Psychometric evaluations i.e. STAXI for Anger Management group.
External agencies, independent bodies, observations, MDT evaluations, progress and treatment reports, treatment summary documents, structured clinical judgement, opinions, R&D programme, self-report & self-audit.

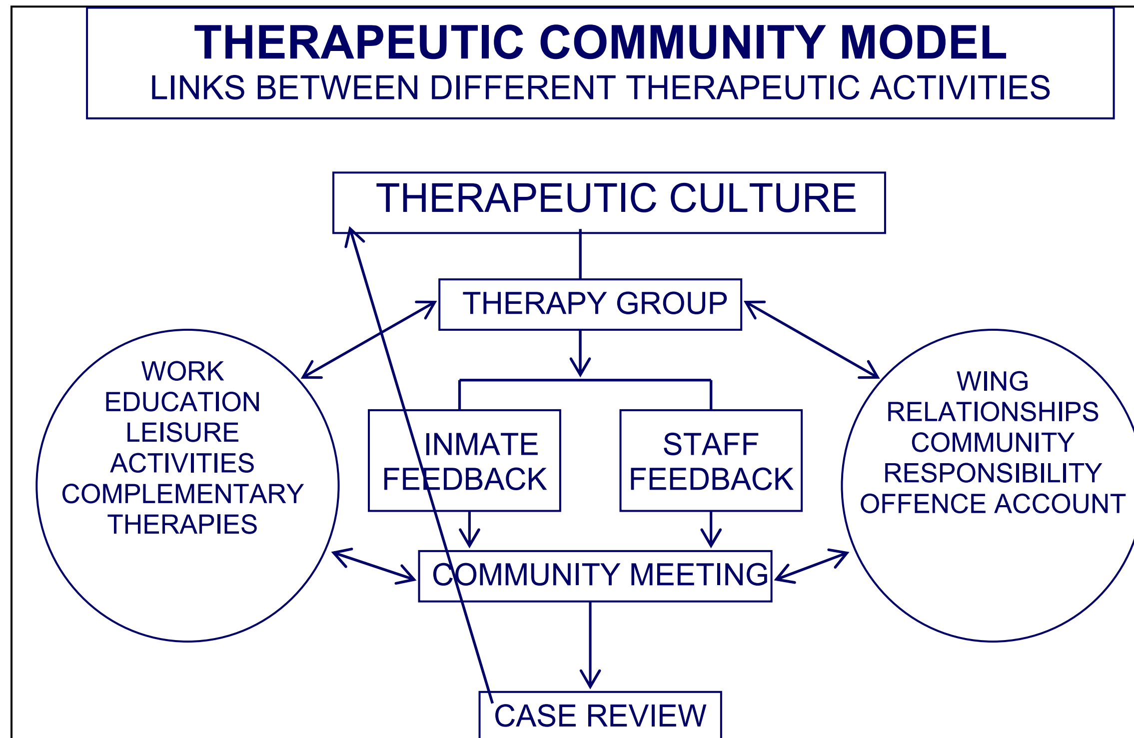
DSPDs were acknowledged as costly. Such costs include the continual training of a staff group which has a high turnover and high level training needs. Such training needs are further compounded by the difficulty in recruitment and retention of staff.

HMP Grendon: a therapeutic community

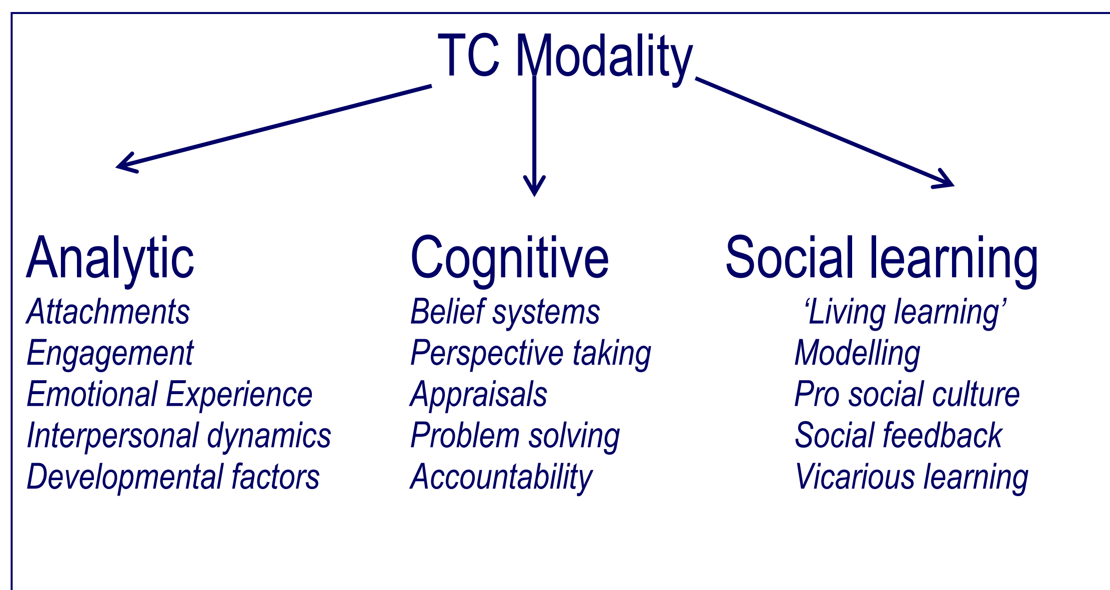
The use of therapeutic communities as a treatment modality for personality disorder is well recognised. Therapeutic Communities (TCs) provide a context for treatment, allow an integration of different therapeutic approaches and can address offence related risk. HMP Grendon is nationally known as a therapeutic community working with difficult prisoners many of whom would fit criteria required for a diagnosis of a personality disorder (Jones, 2004; Shine, 2000). Half the population is serving a life sentence. Eighty percent fulfil criteria for at least one personality disorder and 64% for 2 or more (Derogatis, 1994). One-quarter has a PCL-R score of greater than 30 and almost half have a PCL-R score of greater than 25 (Hobson and Shine, 1998; Gray et al, 2000). Members of the working group visited HMP Grendon on 3rd December 2004.

HMP Grendon opened in 1962 and is a Category "B" prison. It has 230 inmates and approximately 150 admissions each year. Its waiting list has reduced markedly in recent years and has now approximately 20 names. Prisoners with a major mental illness are excluded from HMP Grendon and the prescribing of psychotropic medication is discouraged. Prison officers have a therapeutic role and there is considerable input from psychologists and specific therapists. There is no input from psychiatry. The prison operates a psychodynamic model although willingness to use behavioural or cognitive behavioural approaches was expressed. Eighteen months to 2 years is considered to be the optimal length of stay but some prisoners are there on a long term basis. The prison has 6 wings: one induction wing of 25 beds, and 5 wings

of approximately 42 beds per wing. The prison operates with 3 basic rules: no sex, no drugs and no violence. Each inmate attends 2 x 1.5 hour wing based groups / week (n=42) and 3 x 1.5 hour small groups / week (n=8). The groups are lead by a therapist and supervision of this therapist appeared limited. The assault rate within the prison is one-sixth of comparative establishments



Theoretical Integration



A question and answer session with a self-selected group of prisoners (approximately 8) was held on one of the prison wings. During the meeting the prisoners shared with the visiting group members their offending and prison histories and reflected on life in HMP Grendon and their perspectives on the therapeutic process. The majority of the prisoners were extremely positive about the Grendon experience with only one stating that he had requested transfer. The prisoners were very articulate and had positive therapeutic relationships with staff at Grendon. The prisoners presented their view that a therapeutic community would not work as part of a larger institution, as its fundamental principles required to be embraced by the whole service.

HMP Grendon staff thought that their service may provide a suitable step-down facility from DSPD units in the future.

Points of note

- The positive therapeutic relationships that had developed between staff and prisoners in HMP Grendon were impressive and worthy of emulation within Scottish services.
- There was no clear therapeutic rationale underpinning the group work.
- There was no through care for prisoners after their stay in HMP Grendon.

14.3 Appendix C

Survey of Services for People with Forensic Personality Disorder in Scotland

The Service Mapping Study

The Working Group in its remit was asked:

- To describe services currently available in Scotland for individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system
- To describe treatment strategies currently used in Scotland with this group.

To fulfil the remit, a survey on services for people in Scotland with a diagnosis of personality disorder associated with a risk of violence others was carried out. The survey :

- Mapped the services for the spectrum of personality disorders in each locality
- Addressed assessment issues
- Considered therapeutic and Clinical Management issues and
- Described self-assessed service competencies in line with the recent NIMHE recommendations (Breaking the Cycle of Rejection: The personality Disorder Capabilities Framework, 2003)

The Participants

The survey was sent to the lead psychiatrists in each of the forensic services in Scotland. Responses were received from 10 of the 11 identified services (Ayrshire and Arran, Dumfries and Galloway, Fife, Forth Valley, Glasgow, Grampian, Highlands, South-East of Scotland, The State Hospital and West of Scotland). To augment the data, a similar survey was sent to clinical psychologists who are members of the Scottish Forensic Clinical Psychologists Interest Group. It was considered that as part of their remit, clinical psychologists may often have the task of carrying out structured personality/personality disorder assessments and providing appropriate psychological therapies to people with personality disorder. Fifteen questionnaires were distributed to Clinical Psychologists and five were returned (Glasgow, Forth Valley, Highland, The State Hospital and the Time-out service for women with drug convictions in Glasgow). The survey was distributed three times to improve response rates. The five respondents came from Western Central Scotland, with one further respondent from a rural locality. The results of the survey below may have to be interpreted cautiously, due to the fact that the role of all NHS mental health disciplines in the provision of services for personality disorder has been assessed primarily by Psychiatrists, with responses from a few Clinical Psychologists.

An adapted survey was posted to Directors of Social Work and Chief Social Work Officers throughout Scotland. A total of 46 were sent out, and 11 were returned. Respondents were asked to identify their service locality, but only two did so. Hence, the results must also be interpreted with caution, as we are unable to ascertain the areas which the respondents represented.

The following sections detail the main findings:

SURVEY: SERVICES FOR PEOPLE WITH PERSONALITY DISORDERS

A: The NHS Survey

1. Describing the Services in general

(i) Is there a stated Philosophy of Care or Service Principles on which your service is based? (please detail)

	Psychiatry
Yes	5
In development	1
No	2
The Health Board's over-arching principles	2

(ii) Does your service have admission criteria?

	Psychiatry
Yes	8
Yes, but it is in draft only	1
No	1

(iii) Does your service have admission criteria that exclude 'personality disorder'?

	Psychiatry
Yes	0
No	3
No, buts…	

- No, but we do not admit persons with a primary diagnosis of PD, with the rare exception of people with borderline PD (1)
- No, but only accept if there is a primary mental illness present due to resources (4)
- Only in terms of criteria of MH(S) Act 1984 (2)

Main Findings:

- Given that a significant proportion (50%) of NHS Services surveyed do not have either a stated Philosophy of Care or stated Service Principles, the current position and rights to services for people with Personality Disorder appears to be unclear at a Service Provider level in a number of areas in Scotland.
- It is notable 7 out of the 10 (psychiatry) services surveyed stated that they may implicitly exclude people with a diagnosis of personality disorder from admission to their service.

2. Services for the Spectrum of Personality Disorders

2.1. Assessment Issues

(i) Does your service diagnose/ assess the spectrum of personality disorders?

	Psychiatry	Psychology
Yes	7	3
Yes, if there is also severe and enduring mental illness	1	
No	2	1

(ii) Is the diagnosis of personality disorder made by an individual or a multidisciplinary team? (please detail, and who is involved)

	Psychiatry	Psychology
• formalised by clinical psychology assessment	1	3
• MDT	7	
• RMO	2	

(iii) Does your service <u>diagnose/assess</u> the spectrum of personality disorders associated with a high risk of violence to others?

	Psychiatry	Psychology
Yes	8	3
Yes, mostly by Clinical Psychologists	1	
No	1	1

(iv) If you diagnose/assess specific Personality Disorders, which Diagnostic System do you apply?

	Psychiatry	Psychology
ICD-10	7	
DSM-IV		3
Both ICD and DSM-IV	3	

(v) Does your service <u>routinely</u> use the following to gather information to assist with the diagnosis of personality disorder? (tick all that apply)

	Psychiatry	Psychology
Clinical interview with client	10	4
Collateral interviews	6	3
Multidisciplinary team discussions	10	3
Review of collateral file information	10	3

<u>Structured Assessments</u>:

	Psychiatry	Psychology
IPDE	2	2
MMPI	1	
SCID-II	1	1
PAS		1
NEO	1	
PCL-R	4	3

None of the above	6	1

Main Findings:

- While the results in 'section 1' indicate that the majority of services do not consider it within their service remit to provide inpatient services for PD, the majority of respondents indicated that their service is willing "to assess" the spectrum of personality disorders.
- 7 sites reported that personality disorder assessment is conducted by a MDT. This indicates a good level of MDT working and the planning of appropriate care. The majority of respondents stated that they would assess personality disorder associated with a high risk of violence to others.
- While the majority of respondents used comprehensive methods in their service to collate information related to deriving a diagnosis of PD, very few services used structured assessments to confirm diagnoses. Most appeared to rely upon clinical judgement. Of particular note is that few respondents reported use of the International Personality Disorder Examination, which is probably considered the structured assessment of choice at present. Only four sites reported use of the PCL-R by either Clinical Psychologists or Psychiatrists, which is probably one of the most important assessments of personality traits associated with risk of violent offending. These results may be explained in two main ways. Firstly, that the lack of use is a reflection of training and service development needs. Secondly, the use of these assessments requires a considerable amount of staff resources, in that comprehensive assessment of personality disorder may take several hours of a clinician's time.

2.2. Intervention Issues

(i) Does your service accept people for <u>treatment/management</u> with a <u>primary</u> diagnosis of personality disorder?

	Psychiatry	**Psychology**
No	6	
No for inpatients, yes for outpatients	1	
Yes		5
Yes, estimated <10 patients	3	

(ii) Does your service accept people for <u>treatment/management</u> with a <u>secondary</u> diagnosis of personality disorder?

	Psychiatry	**Psychology**
Yes		
but no idea of numbers	6	5
estimated 15 new per year, 70 ongoing	1	
estimated 50% of both inpatients and outpatients	1	
estimated 50 per year, 25 ongoing	1	

(iii) Does your service accept people for treatment/management with 'abnormally aggressive or seriously irresponsible conduct' in terms of the Mental Health (Scotland) Act 1984?

	Psychiatry	**Psychology**
Yes		
estimated 1 new per year, 7 in total	1	

Yes, no estimate	1	4
Yes, estimated 30, 5 ongoing (as above)	1	
No	7	1

(iv) Does your service accept people for treatment/management with a primary or secondary diagnosis of antisocial personality disorder (DSM-IV) or dissocial personality disorder (ICD-10)?

	Psychiatry	**Psychology**
Yes, but no estimate	7	3
estimated 50% inpatients and outpatients	1	
estimated 45 per year, 20 ongoing	1	
No	2	2

(v) Does your service accept people for treatment/management with a primary or secondary diagnosis of personality disorder which may pose a considerable risk of violence to others?

	Psychiatry	**Psychology**
Yes, but no idea of numbers	7	3
estimated 16 new per year, 75 ongoing	1	
estimated 50% inpatients and outpatients	1	
No	1	2

(vi) Are any specific groups excluded (e.g. sex offenders, those with comorbid substance misuse) from your service (please detail)?

No (all respondents)

(vii) For 'personality disordered' service users, what is the average length of involvement with your service (please detail)?

	Psychiatry	**Psychology**
Don't know	7	5
Not applicable	3	

Main Findings:

- The responses indicate that the many psychiatric services do not accept people with a primary diagnosis (60%) or secondary diagnosis (40%) of PD for treatment / management / intervention. In contrast to this, all Clinical Psychology Services indicated that they would accept these groups for intervention but 2 specifically excluded people with ASPD or a personality disorder which may pose a considerable risk of violence to others.
- The respondents generally were unable to provide reliable estimates of the number of individuals using their services who meet diagnostic criteria for personality disorders. The piecemeal numbers provided do not reflect current epidemiological estimates that between 6-15% of the general population meeting diagnostic criteria for personality disorder (Widiger & Rogers, 1989; Weissman, 1993; Pilkonis et al, 1997; Royal College of Psychiatrists, 1999) and that this is higher in forensic populations. Currently, service users with personality disorders do not have the presence in mental health services that would be expected.

3. Assessment of Risk and Needs in Personality Disorder

(i) Does your service regularly conduct Risk and Needs Assessments of personality disordered clients?

	Psychiatry	Psychology
Risk	9	3
Not regularly	1	2
Needs	9	2
Not regularly	1	3

(ii) Is an assessment of risk and needs in personality disorder made by an individual or a multidisciplinary team? (please detail)

	Psychiatry	Psychology
MDT	7	
MDT and Individual	3	3

(iii) How do you <u>routinely</u> gather information to assist the assessment of risk and needs with service users with a diagnosis of personality disorder? (tick all that apply)

	Psychiatry	Psychology
Clinical Interview with Client	10	4
Collateral Interviews	7	3
Multidisciplinary Team Discussions	9	4
Review of Collateral file information	10	3

<u>Structured Clinical Assessments</u>:

	Psychiatry	Psychology
HCR-20	4	3
SVR-20	2	2
PCL-R	3	3
RSVP	2	3
SARA	2	3
RA 1-5	1	
None Used	4	

<u>Actuarial Assessments of Risk</u>

	Psychiatry	Psychology
VRAG	1	1
SORAG	1	
RRASOR	1	
STATIC-99	1	
Risk Matrix 2000	1	
None Used	5	

Assessments of Needs

	Psychiatry	Psychology
Camberwell Assessment of Needs		
No	9	3
Yes	1	2
Level of Service Inventory		
No	10	2
Yes		3

(iv) Is a risk management plan routinely formulated on the basis of this?

	Psychiatry	Psychology
Yes	8	3
No	2	1

(v) Who is responsible for monitoring the risk management plan at either an individual level or as part of a multidisciplinary team?

Service	Has significant individual responsibility	Has responsibility as part of MDT
Social Work	3	8
Housing Support		
Occupational Therapy	1	5
Nursing	4	10
Psychiatry/ RMO	10	9
Psychology	5	9
'Untrained' support workers	1	
Psychotherapy		
Counsellors		
Key worker	1	4
Client Advocacy		1

(vi) Do you use the Care Programme Approach for personality disordered clients?

	Psychiatry	Psychology
Yes	7	3
No	3	2

(v) Do you routinely use Integrated Care Pathways for personality disordered clients?

	Psychiatry	Psychology
Yes	2	2
No	8	3

(vi) How does your service promote integrated, inter-agency or inter-disciplinary practice?

	Psychiatry	Psychology
CPA	4	2

'Service Policy' 1

Main Findings:

- The majority of service sites reported that they regularly conducted risk and needs assessments for service users with diagnosis of personality disorder. The majority of the respondents reported that this was frequently conducted by the MDT, but a significant proportion of respondents reported that this was sometimes done by the MDT and sometimes by an individual clinician – usually a clinical psychologist. This has implications for best-practice risk management planning.

- While the majority of respondents used comprehensive methods in their service in order o collate information related to conducting a risk and needs assessment and management strategy, very few services used structured clinical assessments in risk and needs management. By far the majority of services appeared to rely upon clinical judgement alone. Only 6 sites (60%) would routinely used the HCR-20, 2 sites (20%) the SVR-20, 3 sites (30%) the PCL-R, and 2 sites (20%) the RSVP. Given the incongruence of use of the HCR-20 with the PCL-R (only 50% of those using the HCR-20 incorporated the PCL-R into this) there is indication that 'personality disorder' may not be adequately considered in risk assessment and management. It is clear that a number of services are routinely formulating risk management plans on the basis of current assessment techniques. From the responses, it appears that in a number of localities, the development of the use of structured clinical assessments may require to be developed in order to inform 'good practice' standards in the development of risk management plans. Indeed, this may be a reflection of training needs, but more importantly is likely to reflect funding/resourcing issues.

- In terms of monitoring risk management, there was considerable evidence of multidisciplinary working across Scotland; but in the majority of cases, the RMO considered they had the most significant personal responsibility.

- There is evidence that in a number of localities, the needs of service users with personality disorder are considered complex enough to warrant the use of the Care Programme Approach. Only two localities had systems currently available in their service for the use of Integrated Care Pathways to plan and monitor care.

4. Therapeutic/Clinical Management Services for Clients with Personality Disorder

Which of the following services and interventions are currently available for clients with a primary or secondary diagnosis of personality disorder in your service (please tick)?

Service	Currently available to clients with a diagnosis of a personality disorder
Services:	No of NHS localities in Scotland (10)
Social Work	9
Housing Support	6
Occupational Therapy	6
Nursing	10
Psychiatry	10
Psychology	8
‘Untrained’ support workers	5
Drop-in facilities	4
Client Advocacy	7
Specific Interventions:	
Drug and Alcohol services	9
Cognitive Behavioural therapy (individual basis)	7
Cognitive Behavioural therapy (groupwork basis)	4
Psychotherapy (individual)	4
Psychotherapy (group)	0
Counselling	2
Dialectical behaviour therapy	2
Therapeutic Community	0
Structured Psychoeducation:	
Anger Management	9
Relapse Prevention	4
Sex Offending	4
Moral Reasoning	1
Problem-Solving Training	1
‘Cognitive Skills’	3
Social Skills Training	4
Activities of daily living	8

Main Findings:

- This simplistic service mapping provides rudimentary evidence that there are piecemeal services available to service users with a diagnosis of personality disorder throughout Scotland. While the majority of services indicate that service users will have access to Psychiatry and Nursing at some level, their access to other services is not consistent. All of the respondents indicated that clients could access drug and alcohol services (and indeed there are often such co-morbid problems associated with personality disorder), or specific therapeutic work around anger management, or activities of daily living. It was notable that rural localities were more equipped to provide higher levels of support work, drop-in facilities, and client advocacy and generic counselling.

- Access to the more specific forms of therapy which are considered to have some proven efficacy for service users with a diagnosis of personality disorder appears more limited with individual psychotherapy available in 6 sites, CBT at 9 sites and DBT at 2 sites.

- In terms of specialist psychological interventions associated with risk of violence, only 4 sites were able to provide appropriately tailored programmes around relapse prevention, sex offending, and problem-solving training to clients with a diagnosis of personality disorder. The respondents did not indicate whether these services are available on an inpatient or an outpatient basis.

5. Competencies and Training Needs

Promoting Social Functioning in Personality Disordered Clients

How confident are you that your service is….

Able to support staff in maintaining positive attitudes to working with clients with personality disorder?

	Psychiatry	**Psychology**
1 Low Confidence	2	1
2	3	2
3	5	2
4 High Confidence		

Able to contribute to the development of positive strategies for challenging stigma and promoting social inclusion in partnership with service users?

	Psychiatry	**Psychology**
1 Low Confidence	3	2
2	3	2
3	4	1
4 High Confidence		

Able to refer to other agencies to obtain social resources for personality disordered service users and their family or carers?

	Psychiatry	Psychology
1 Low Confidence	5	4
2	3	
3	1	1
4 High Confidence	1	

Able to advocate on behalf of social networks of personality disordered service users & their carers?

	Psychiatry	Psychology
1 Low Confidence	7	3
2	2	
3	1	2
4 High Confidence		

Able to develop and deliver therapeutic interventions aimed at improving and sustaining coping skills?

	Psychiatry	Psychology
1 Low Confidence	5	1
2	2	1
3	2	2
4 High Confidence	1	1

Able to apply concepts of boundary maintenance to interactions with individuals?

	Psychiatry	Psychology
1 Low Confidence	3	
2	1	1
3	5	4
4 High Confidence	1	

Able to provide support and supervision of specialist staff?

	Psychiatry	Psychology
1Low Confidence	4	
2	4	1
3	1	2
4 High Confidence	1	2

Able to provide support and supervision of non-specialist staff?

	Psychiatry	Psychology
1 Low Confidence	4	1
2	4	1
3	1	3
4 High Confidence	1	

Able to support reflective practice for individuals?

	Psychiatry	**Psychology**
1 Low Confidence	3	
2	3	
3	2	5
4 High Confidence	2	

Able to support reflective practice in teams?

	Psychiatry	**Psychology**
1 Low Confidence	2	
2	3	
3	3	2
4 High Confidence	2	3

Main Findings:

- While a range of responses were apparent across most of the competencies relating to social functioning, the most salient findings were that a significant proportion of services lacked confidence in their:
    - Abilities to refer to other agencies to obtain social resources for personality disordered service users and their family/carers.
    - Abilities to advocate on behalf of social networks of people with personality disorder and their carers
    - Abilities to develop and deliver therapeutic interventions aimed at improving and sustaining service user's coping skills.

Clinical Psychologists expressed greater confident in their:

- Abilities to provide support and supervision for specialist staff and non specialist staff alike
- Abilities to apply concepts of boundary maintenance to interactions with individuals.
- Abilities to support reflective practice for individuals and teams.

Improving Psychological well-being in personality disordered Clients

How confident are you that your service is……

Able to apply a critical understanding to theories of personality disorder and consider the reliability and validity of the diagnoses?

	Psychiatry	Psychology
Low Confidence	1	1
2	4	1
3	4	1
4 High Confidence	1	2

Able to understand the symptoms, and implications on social functioning?

	Psychiatry	Psychology
Low Confidence	3	2
2	3	
3	3	1
4 High Confidence	1	2

Able to clinically assess personality disorder and its associated mental health needs, and use this to contribute to care and treatment plans in an informative way?

	Psychiatry	Psychology
Low Confidence	1	1
2	4	1
3	4	1
4 High Confidence	1	2

Able to apply case formulation, based on a range of evidence based models?

	Psychiatry	Psychology
Low Confidence	3	
2	4	1
3	2	1
4 High Confidence	1	3

Able to assess co-morbid factors in personality disorder?

	Psychiatry	Psychology
Low Confidence	1	1
2	3	
3	4	1
4 High Confidence	2	3

Able to apply a range of evidence-based interventions for personality disorder?

	Psychiatry	Psychology
Low Confidence	4	
2	3	3
3	2	2
4 High Confidence	1	

Able of collaborating with multidisciplinary colleagues and services to provide integrated care

	Psychiatry	Psychology
Low Confidence	5	
2	2	3
3	2	1
4 High Confidence	1	1

Able to tolerate frustration and anxiety in working with personality disordered people

	Psychiatry	Psychology
Low Confidence	2	
2	3	3
3	4	1
4 High Confidence	1	1

Main Findings:

While a range of responses were apparent across most of the competencies relating to the promotion of psychological well-being for people with a diagnosis of personality disorder, the most salient findings were that a significant proportion of services lacked confidence in their:
Abilities to apply case formulation based on a range of evidence-based models
Abilities to apply a range of evidence-based interventions for personality disorder
Abilities to collaborate with multidisciplinary colleagues and services to provide integrated care.

Psychiatric Services felt reasonably competent in their abilities to:
Assess co-morbid factors in personality disorder
Clinically assess personality disorder and use to create an informative care plan
Tolerate frustration and anxiety in their work.

Clinical Psychologists felt reasonably competent in their abilities to:
Understand symptoms, and implication on social functioning
Assess co-morbid factors in personality disorder
Abilities to apply case formulation based on a range of evidence-based models

Assessing and Managing Risk to Others in Personality Disordered Clients

How confident are you that your service is……

Able to apply structured clinical and actuarial risk assessment paying attention to the risk of offending and of harm to self/others?

	Psychiatry	Psychology
Low Confidence	3	1
2	1	1
3	3	
4 High Confidence	3	3

Able to understand and promote a dynamic risk and needs assessment paying particular attention to the cognitive and interpersonal factors, substance abuse and lifestyle factors?

	Psychiatry	Psychology
Low Confidence	3	1
	3	1
3	2	
4 High Confidence	2	3

Able to conduct a family and community risk and needs assessment?

	Psychiatry	Psychology
Low Confidence	8	3
2	1	1
3	1	
4 High Confidence		1

Able to plan and deliver interventions based on case formulation addressing specific risk factors, providing proposals for risk management and motivating individuals?

	Psychiatry	Psychology
Low Confidence	4	1
2	1	1
3	3	
4 High Confidence	2	3

Able to apply an understanding of legal and ethical issues in the context of risk assessment and management?

	Psychiatry	Psychology
Low Confidence	2	1
2	2	1
3	4	
4 High Confidence	2	3

Able to devise multidisciplinary risk management plans?

	Psychiatry	Psychology
Low Confidence	1	
2	4	1
3	2	
4 High Confidence	4	2

Able to collaborate with multidisciplinary risk management plans?

	Psychiatry	Psychology
Low Confidence	1	
2	5	1
3	4	
4 High Confidence	1	3

Able to engage in reflective practice on risk and needs assessment?

	Psychiatry	Psychology
Low Confidence	2	1
2	4	1
3	2	
4 High Confidence	2	3

Main Findings:

While a range of responses were apparent across most of the competencies relating to the assessment and management of risk for people with a diagnosis of personality disorder, the most salient findings were that a significant proportion of services lacked confidence in their abilities to:

Conduct a family and community risk and needs assessment
Engage in reflective practice on risk and needs assessment.

Services felt reasonably competent in their abilities to:
Plan and deliver interventions based on case formulation and address specific risk factors.
Apply an understanding of the legal and ethical issues in the contest of risk assessment and management.
Devise multidisciplinary risk management plans.
Collaborate with multidisciplinary risk management plans.

B: The Social Services Survey

1. About your Local Authority

Which of the following services are routinely available to your clients through your organisation? (please tick)

Service	Directly provided	Indirectly Purchased
Social Work	9	
Housing Support	4	4
Occupational Therapy	7	
Nursing	5	
Psychiatry	5	
Psychology	4	
‘Untrained’ support workers	6	3
Psychotherapy	2	
Counsellors	2	1
Drop-in facilities	1	6
Mental Health outreach	5	
Mental Health in reach	3	
Availability of a key worker	6	
Client Advocacy	3	2
Mentoring/Befriending	1	3
Home Care	1	
Employment Advice	1	

(ii) Does your organisation exclude ‘personality disorder’?

Yes 0
No 10

Yes, buts…
Only if they have co-existing mental illness 1

Should people with Personality Disorder be able to access all existing services offered by your organisation?

Yes 10
No

Yes buts,
Only if they have existing mental illness 1

2. Services for the Spectrum of Personality Disorders

(i) Does your service diagnose/assess the spectrum of personality disorders?

Yes	2
No	9

(ii) Is the diagnosis of personality disorder made by an individual or a multidisciplinary team? (please detail, and who is involved)

Psychiatrists	2
Multidisciplinary Clinical Team	2
Not applicable	9

(iii) Does your service diagnose/assess the spectrum of personality disorders associated with a high risk of violence to others?

Yes	2
No	9

(iv) If you diagnose/assess specific Personality Disorders, which Diagnostic System do you apply?

ICD-10	
DSM-IV	1
Both ICD and DSM	

(v) Does your organisation use the following to gather information to assist with the diagnosis of personality disorder? (tick all that apply)

Clinical interview with client	3
Collateral interviews	2
Multidisciplinary team discussions	3
Review of collateral file information	2
Not applicable	7

Structured Assessments:

IPDE	
MMPI	
SCID-II	
PAS	
NEO	
PCL-R	
None of the above	11

(vi) Does your organisation accept people for treatment/management with a primary diagnosis of personality disorder?

Yes	9

No	2

(vii) Does your organisation accept people for treatment/management with a secondary diagnosis of personality disorder?

Yes	9
No	2

(viii) Does your organisation accept people for treatment/management with 'abnormally aggressive or seriously irresponsible conduct' in terms of the Mental Health (Scotland) Act 1984 ?

Yes	9
No	2

(ix) Does your organisation accept people for treatment/management with a primary or secondary diagnosis of antisocial personality disorder (DSM-IV) or dissocial personality disorder (ICD-10)

Yes	9
No	2

(x) Does your organisation accept people for treatment/management with a primary or secondary diagnosis of personality disorder which may pose a considerable risk of violence to others?

Yes	9
No	2

(xi) Are any specific groups excluded (e.g. sex offenders, those with comorbid substance misuse) from your organisation (please detail)?

No	11

(xii) For 'personality disordered' service users, what is the average length of involvement with your organisation (please detail)?

Residential
Non-Residential

(xiii) Are you aware of any service gaps for people with Personality Disorder in your organisation?

'Yes, services based on structured engagement'
'There is no service!'
'Training for staff around personality disorder'
'No clear assessments available of PD'
'Access to service variable dependent on whether it is a primary or secondary diagnosis'

‘Trying to support service users when they meet criteria for our services but not for mental health MDTs. Doing this without specialist training and resources is very difficult.’
‘Need to widen the range of support services for them’
‘A proper treatment unit’
‘Adequate outreach and in reach services’
‘A Clinical Psychology Service’

(xv) Do you have any ring-fenced service for this group ?

Yes	
No	11

Main Findings:

- In comparison to the NHS respondents, it would appear as though Social Services respondents indicated that service users with a diagnosis of personality disorder would be able to access a comparable set of services but with the inclusion of housing support, mental health in reach, and drop-in facilities.

- The majority (9, 81%) of respondents did not consider the diagnosis of personality disorder as their remit, and indicated that was usually done by a multidisciplinary mental health team.

- None of the respondents indicated that they were familiar with the current preferred structured assessments of personality disorder.

- In contrast to the NHS respondents, there appeared to be no evidence of ‘gatekeeping’ in Social Services – where service users with a diagnosis of personality disorder would be able to access all available services provided in the organisations of 10 (90%)of the respondents.

- Indeed 9 (81%) of the respondents indicated that their service was willing to accept people into their service with a primary or secondary diagnosis of personality disorder, including antisocial personality disorder, or personality disorders associated with a risk of violence to others

- Such services were provided in the absence of ring fenced money in all cases. Respondents gave several examples of current gaps in services for personality disordered service users which required development.

3. Assessment of Risk and Needs in Personality Disorder

(i) Does your service regularly conduct Risk and Needs Assessments of personality disordered clients?

Risk	10
Needs	8

(ii) Is an assessment of risk and needs in personality disorder made by an individual or a multidisciplinary team? (please detail)

Individual, by Social Worker	2
MDT	10
MDT, coordinated by named worker using SSA template	1

(iii) How do you routinely gather information to assist the assessment of risk and needs with service users with a diagnosis of personality disorder? (tick all that apply)

Clinical Interview with Client	6
Collateral Interviews	5
Multidisciplinary Team Discussions	6
Review of Collateral file information	4

Structured Clinical Assessments:

HCR-20	1
SVR-20	
PCL-R	
RSVP	
SARA	
RA 1-5	2
None Used	8

Actuarial Assessments of Risk

VRAG	
SORAG	
RRASOR	
STATIC-99	
Risk Matrix 2000	
None Used	11

Assessments of Needs

Camberwell Assessment of Needs	
No	11
Level of f Service Inventory	
No	11
Sainsbury Risk Assessment Tool	1

(iv) Is a risk management plan routinely formulated on the basis of this?

Yes 9
No 2

(v) Who is responsible for monitoring the risk management plan at either an individual level or as part of a multidisciplinary team?

Service	**Has significant individual responsibility**	**Has responsibility as part of MDT**
Social Work	7	5
Housing Support		2
Occupational Therapy	3	4
Nursing	5	3
Psychiatry/ RMO	5	4
Psychology	2	2
'Untrained' support workers	2	2
Psychotherapy		
Counsellors		
Key worker	7	2
Client Advocacy		
Other (please specify)		

(vi) Do you use the Care Programme Approach for personality disordered clients?

Yes Where indicated 10
No 1

(v) Do you routinely use Integrated Care Pathways for personality disordered clients?

Yes 5
No 6

(vi) How does your service promote integrated, inter-agency or inter-disciplinary practice?

Multidisciplinary teams 9
CPA process 5
Single, shared assessment 5

Main Findings:

- The majority of service sites reported that they regularly conducted risk (10, 90%) and needs assessments (8, 73%) for service users with diagnosis of personality disorder. Again, the majority of respondents (10, 90%) indicated that this was conducted by the MDT.

- Similar to the NHS respondents, the majority of Social Services respondents indicated the use of comprehensive methods in their service in order collate information related to conducting a risk and needs assessment and management strategy, very few services (3, 27%) were familiar with the use of structured clinical assessments in risk and needs management. Similar to the NHS respondents, the majority (9, 81%) indicated that their services were routinely formulating risk management plans on the basis of current assessment techniques. Similar to the NHS respondents, there is evidence to suggest the need for the development of the use of structured clinical assessments in a number of localities. No doubt, this is also likely to be a reflection of resource and funding issues

- In terms of monitoring risk management, there was considerable evidence of multidisciplinary working across Scotland with Social Workers and key workers (roles may be inter-changeable) indicating significant responsibilities.

- There is evidence that in the majority of localities (9, 81%), the needs of service users with personality disorder are considered complex enough to warrant the use of the Care Programme Approach. A similar proportion of Social Services respondents (5, 45%) indicated the use of Integrated Care Pathways to plan and monitor care.

4. Therapeutic/Clinical Management Services for Clients with Personality Disorder

Which of the following services and interventions are currently available for clients with a primary or secondary diagnosis of personality disorder in your service (please tick)?

Service	**Currently available to clients with a diagnosis of a personality disorder associated**
Services:	
Social Work	8
Housing Support	8
Occupational Therapy	8
Nursing	5
Psychiatry	5
Psychology	5
'Untrained' support workers	6
Drop-in facilities	6
Client Advocacy	7
Specific Interventions:	
Drug and Alcohol services	6
Cognitive Behavioural therapy (individual basis)	4
Cognitive Behavioural therapy (groupwork basis)	
Psychotherapy (individual)	2
Psychotherapy (group)	
Counselling	3
Dialectical behaviour therapy	1
Therapeutic Community	
Structured Psychoeducation:	
Anger Management	4
Relapse Prevention	4
Sex Offending	
Moral Reasoning	
Problem-Solving Training	4
Social Skills Training	6
Activities of daily living	5
Interpersonal relationships	3

Main Findings:

- This simplistic service mapping provides rudimentary evidence that there are similarly piecemeal services available to Social Services service users with a diagnosis of personality disorder as there are throughout the NHS in Scotland. Respondents indicated the same range of services being available to them, but with less frequency than their NHS colleagues, While the majority of services indicate that service users will have access to social Work, Housing, Occupational Therapy and Client Advocacy, and support workers at some level, their access to other services is not consistent. Nonetheless, taken in conjunction with the NHS availability, there is potential for the development for a more cohesive set of services for service users with Personality Disorder.

5. Competencies and Training Needs

Promoting Social Functioning in Personality Disordered Clients

How confident are you that your service is….

Able to support staff in maintaining positive attitudes to working with clients with personality disorder?

Low Confidence	3
2	3
3	3
5 High Confidence	

Able to contribute to the development of positive strategies for challenging stigma and promoting social inclusion in partnership with service users?

1 Low Confidence	2
2	1
3	6
4 High Confidence	

Able to refer to other agencies to obtain social resources for personality disordered service users and their family or carers?

1 Low Confidence	3
2	
3	4
4 High Confidence	2

Able to advocate on behalf of social networks of personality disordered service users & their carers?

1Low Confidence	2
2	2
3	3
4 High Confidence	2

Able to develop and deliver therapeutic interventions aimed at improving and sustaining coping skills?

1Low Confidence	2
2	4
3	3
4 High Confidence	

Able to apply concepts of boundary maintenance to interactions with individuals?

1Low Confidence	1
2	7
3	
4 High Confidence	1

Able to provide support and supervision of specialist staff?

1Low Confidence	3
2	2
3	4
4 High Confidence	

Able to provide support and supervision of non-specialist staff?

1Low Confidence	1
2	1
3	7
4 High Confidence	

Able to support reflective practice for individuals?

1Low Confidence	1
2	2
3	5
4 High Confidence	1

Able to support reflective practice in teams?

1Low Confidence	1
2	2
3	6
4 High Confidence	

Main Findings:

- While a range of responses were apparent across most of the competencies relating to social functioning, the most salient findings were that a significant proportion of services lacked confidence in their:
    - Abilities to support staff in maintaining a positive attitude towards working with personality disorder
    - Abilities to develop and deliver therapeutic interventions aimed at improving and sustaining service user's coping skills.
    - Abilities to apply boundary maintenance

Respondents were more confident in their Organisation's abilities to:

- Contribute to the development of positive strategies for challenging stigma and promoting social inclusion in partnership with service users

- In comparison to their NHS colleagues, Social Services respondents appeared to show a higher level of confidence in their :
  - Abilities to refer to other agencies to obtain social resources for personality disordered service users and their family/carers.
  - Abilities to advocate on behalf of social networks of people with personality disorder and their carers
  - Abilities to provide support and supervision for specialist staff and non specialist staff alike
  - Abilities to support reflective practice for individuals and teams.

Improving Psychological well-being in personality disordered Clients

How confident are you that your service is……

Able to apply a critical understanding to theories of personality disorder and consider the reliability and validity of the diagnoses?

1Low Confidence	3
2	5
3	1
4 High Confidence	

Able to understand the symptoms, and implications on social functioning?

1Low Confidence	1
2	6
3	
4 High Confidence	2

Able to clinically assess personality disorder and its associated mental health needs, and use
this to contribute to care and treatment plans in an informative way?

1Low Confidence	5
2	1
3	3
4 High Confidence	

Able to apply case formulation, based on a range of evidence based models?

1Low Confidence	4
2	3
3	2
4 High Confidence	

Able to assess co-morbid factors in personality disorder?

1Low Confidence	5
2	1
3	3
4 High Confidence	

Able to apply a range of evidence-based interventions for personality disorder?

1Low Confidence	6
2	4
3	
4 High Confidence	

Able of collaborating with multidisciplinary colleagues and services to provide integrated care?

1 Low Confidence	1
2	2
3	3
4 High Confidence	3

Able to tolerate frustration and anxiety in working with personality disordered people?

1Low Confidence	1
2	**1**
3	7
4 High Confidence	

Main Findings:

- While a range of responses were apparent across most of the competencies relating to the promotion of psychological well-being for people with a diagnosis of personality disorder, the most salient findings were that a significant proportion of services lacked confidence in their abilities to:
  - Apply a critical understanding to theories of personality disorder and consider the reliability and validity of the diagnoses.
  - Understand the symptoms, and implications on social functioning.
  - Clinically assess personality disorder and use to create an informative care plan
  - Apply case formulation based on a range of evidence-based models
  - Assess co-morbid factors in personality disorder
  - Apply a range of evidence-based interventions for personality disorder

- Services felt reasonably competent in their abilities to:
  - Collaborate with multidisciplinary colleagues and services to provide integrated care
  - Tolerate frustration and anxiety in their work.

Assessing and Managing Risk to Others in Personality Disordered Clients

How confident are you that your service is……

Able to apply structured clinical and actuarial risk assessment paying attention to the risk of Offending and of harm to self/others?

1Low Confidence	3
2	2
3	3
4 High Confidence	

Able to understand and promote a dynamic risk and needs assessment paying particular needs to the cognitive And interpersonal factors, substance abuse and lifestyle factors?

1Low Confidence	3
2	2
3	3
4 High Confidence	

Able to conduct a family and community risk and needs assessment?

1Low Confidence	*2*
2	2
3	4
4 High Confidence	

Able to plan and deliver interventions based on case formulation addressing specific risk factors, providing proposals for risk management and motivating individuals?

1Low Confidence	2
2	1
3	5
4 High Confidence	

Able to apply an understanding of legal and ethical issues in the context of risk assessment and management?

1Low Confidence	2
2	3
3	4
4 High Confidence	

Able to devise multidisciplinary risk management plans?

1Low Confidence	4
2	3
3	1
4 High Confidence	

Able to collaborate with multidisciplinary risk management plans?

1Low Confidence	1
2	
3	7

4 High Confidence

Able to engage in reflective practice on risk and needs assessment?

1Low Confidence	1
2	1
3	6
4 High Confidence	

Main Findings:

- While a range of responses were apparent across most of the competencies relating to the assessment and management of risk for people with a diagnosis of personality disorder, the most salient findings were that a significant proportion of services lacked confidence in their abilities to:
  - Apply structured clinical and actuarial risk assessments (to be expected)
  - Understand and promote a dynamic risk and needs assessment paying particular needs to cognitive and interpersonal factors, substance misuse
  - Devise Multidisciplinary risk plans.

- Services felt reasonably competent in their abilities to:
  - Collaborate with multidisciplinary risk management plans.
  - Engage in reflective practice on risk and needs assessment

14.4 Appendix D

Personality Disorder Case Vignettes

Vignette 1

Alan aged 28 is serving a 9 year sentence for the abduction and rape of a stranger. He was physically abused by his father and was in special schools due to bullying, violence and truancy. He married when he was 19 and has a son, but his wife left for a women's refuge due to his controlling and violent behaviour. He is suspected by the police of having committed two rapes against strangers but has not been charged as there was insufficient evidence. In prison he has caused no problems and is seen by the prison staff as well disciplined and a good worker. He is due to be considered for parole soon. He is a skilled liar, denies and minimises many aspects of his previous behaviour. He has participated in a sex offender programme which he feels has been of little benefit to him.

Vignette 2

Brian aged 25 is serving a 4 year sentence for assaulting a man with a broken bottle in a pub. He claims the man made homosexual advances towards him. He was sexually abused during childhood by his step father and by care workers at a residential home. He was taken into care as his mother was unable to look after him due to her drug abuse and repeated admissions to hospital due to overdoses and depression. He started cutting himself as a teenager and since his teens has been impulsive, quick to lose his temper and mistrusting of others, especially men. He has had a number of short-term relationships with women, which have ended due to his alcohol abuse, drug taking, offending and violence when intoxicated. He has a number of previous convictions for assault, breach of the peace, possession of drugs, stealing cars and theft. In prison he has tested positive for cannabis and opiates, he has harmed himself on a number of occasions (cutting and biting himself and smashing his head against walls) and has assaulted other prisoners. Consequently he has spent long-periods of time in segregation and he has been seen by mental health staff frequently.

Vignette 3

Colin aged 47 is detained at the State Hospital under a hospital order with a restriction order. He was admitted 26 years ago following a conviction for the sexually motivated homicide of a 7 year old girl. He was brought up by his mother who sexually abused him. He was an introverted child and teenager, with few friends and an interest in violence from an early age. He admits to sadistic paedophilic fantasies from his early teens. At the time of the index offence he was diagnosed as having a psychopathic personality and pled guilty to culpable homicide. In the State Hospital he remains an isolated, sensitive individual who finds it difficult to relate to others. There have been no concerns about his behaviour within the hospital. He has attended a group for sex offenders, which he found difficult to tolerate. He now has ground access, but no local service will consider him for transfer as he is considered to pose a high risk to children.

Vignette 4

Duncan aged 21 has always been an isolated individual who has felt that others treat him unfairly and look down on him. He managed to gain some qualifications at school and has since then worked as a technician at an opticians. He has been unable to form any long-term relationships, is socially awkward and ruminates about perceived slights by people at his work and in his neighbourhood. Since leaving school he has had fantasies of going to his former school, work or neighbours houses and killing as many people as he can. These fantasies have become more intense, frequent and preoccupying recently. His father, with whom he lives has found diaries detailing his fantasies, and has asked the GP to arrange to have his son assessed.

Vignette 5

Edward aged 35 is living in the community. He has served a prison sentence for indecent assault. He was a shy teenager, particularly with girls. He married his first girlfriend. He allowed her to make all decisions and is regarded by others as passive and laid back. He worked selling tickets at a train station. The victims of the offence were his two nieces aged 5 and 7 who he and his wife had been looking after while his sister-in-law worked night shifts. He received a three year prison sentence during which he undertook group treatment for sex offenders. His wife left him and he is now living alone in a flat in the community. He is concerned that he may offend again, and has been referred to psychiatric services by his GP.

Vignette 6

Frank aged 28 is an inpatient in a general psychiatry service. He was sexually abused over a period of 6 years by his step-father. When he disclosed the abuse to a teacher, his mother did not believe him and he was put into the care of his grand-parents. He was impulsive and disruptive throughout his schooling. He was frequently involved in fights and truanted regularly. He started cutting himself when angry, frustrated or dejected as a teenager. He has misused alcohol and illicit substances. He has had a number of short-term relationships with women and has been confused about his sexuality. He has had convictions for minor assault, theft, stealing cars, breach of the peace, resisting arrest and possession of drugs. His longest prison sentence was 6 months. He has had a number of admissions to psychiatric hospital. Diagnoses have included personality disorder, alcohol and drug dependence, drug induced psychosis and depression. He has taken many overdoses and continues to cut himself. In hospital he has been verbally abusive and physically assaultative towards staff. Attendance for follow-up has been erratic, with him tending to present as an emergency at times of crisis. His current admission was precipitated by an overdose following the break up of a relationship. He has been told he is not mentally ill and that he does not need to be in hospital. He has threatened to return and burn down the ward if he is discharged.

Vignette 7

John is 25 and is charged with abduction and rape. He is a single unemployed man who was living with his mother at the time of his arrest. His father drank heavily and was physically abusive to his mother, siblings and John. His mother has a history of depression and self-harm. His two brothers both have substance misuse problems and

have committed minor offences. A paternal uncle suffered from schizophrenia. He has had behavioural problems since an early age. He was violent towards other children at school leading to his exclusion from primary school at the age of 9. He was taken into residential care at the age of 11. There he was sexually abused by care workers. He continued to be violent, ran off and was sexually abusive towards female staff and residents. He was transferred to a secure school. At 16 he returned to live with his mother and brothers. He has lived with his mother on and off since then. He has had few friends and is unable to sustain relationships. He has done some short-term labouring work, but has been unemployed for most of his life. He started drinking at the age of 16 getting drunk at the weekend. More recently his main substances of abuse have been cannabis and amphetamine. He was seen by child and adolescent mental health services and was diagnosed with ADHD and unsocialised conduct disorder. He has been assessed following several episodes of self-harm (overdoses and cutting wrists) and has been diagnosed as personality disordered. During his previous prison sentence he presented with psychotic symptoms which responded well to medication. He was diagnosed as suffering from drug induced psychosis. He has convictions for assault, breach of the peace, possession of drugs and indecent exposure. He served two years of a 4 year sentence for the attempted rape of a stranger at the age of 21. It was during this sentence that he first presented with psychotic symptoms, but he was not psychotic at the time of the offence. For about 4 months prior to the index offence he had been using increasing amounts of cannabis and amphetamine. His family were concerned as he was withdrawing into his bedroom and was talking to himself. He was pre-occupied with religion. The index offence involved the abduction at knife point of a 20 year old woman who he grabbed in an alley way. He forced her into an abandoned warehouse where he raped her. He was soon arrested and told the police that he was a special disciple of Satan and that he had the right to have sex with any woman on earth.