POSITION PAPER

Psychological Approaches to Personality Disorder in Forensic Mental Health Settings

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on behalf of the
Scottish Group of Forensic Clinical Psychologists

Prior to submission to the IRG the author shared this paper with colleagues in the field for consultation and feedback. The paper was shared with the Psychology Forensic Matrix Group and with key professionals with an interest in this area. Their contribution was gratefully received. Those consulted were:

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Introduction

The Inter-Regional Group has requested a position paper following recent developments in training opportunities for staff in psychological therapies aimed at addressing personality dysfunction. This paper will discuss personality disorder and why it is important in forensic settings, issues in the assessment and treatment of personality disorder, and outline different ways of intervening to minimise the distress and disruption caused to both the patient and others. It is not a systematic review of the literature but is based on recent research literature and practice developments.

The Forensic Network has previously produced 'A Report of the Working Group on Services for People with Personality Disorder' (Thomson et al, 2005). That comprehensive report looked at the prevalence, assessment and treatment of personality disorder but also the services available for offenders with personality disorder, both in prison, hospital and the community in Scotland at that time. This report made several recommendations, including more services for people with personality disorder within Forensic Mental Health; greater joint working between forensic mental health and criminal justice social work and MAPPA; greater recognition of Personality Disorder as a co-morbid diagnosis; the development of case formulations that incorporate personality pathology in order that intervention can target problems behaviours that are related to risky behaviour; and the dissemination of knowledge held within adult forensic mental health services to not only CAMHS but social work and youth justice services.

This paper seeks to build on this previous piece of work by focusing on developments within the field of psychology and psychotherapy. It does not include a survey of available services, as this previous paper did, instead providing an update on the research literature on assessment and treatment, highlighting the current emphasis on the need for supervision and reflective practice when working with this client group, as well as highlighting the new models of structured clinical care that have been developed. Finally it will address training needs that arise out of this new learning and make recommendations for minimum standards for services that manage or care for offenders who have personality disorder.

Recent training opportunities that have been available to forensic clinicians in Scotland include: Cognitive Behaviour Therapy (CBT) for Personality Disorder which was delivered to a group of Forensic Clinical Psychologists across Scotland by Professor Kate Davidson, Consultant Clinical Psychologist, funded by NES; Cognitive Analytic Therapy (CAT) skills training in Forensic settings (a 5-day course) provided to a range of clinicians, funded by NES; and Mentalisation-Based Therapy (MBT) Skills and Awareness Training in Forensic Settings (3-day training) which is a NES training course that has been provided on a number of occasions to clinicians from various professional backgrounds.

What is Personality Disorder?

The term 'Personality' is used to describe an individual's characteristic ways of relating to others, experiencing and expressing emotion, thinking about self and others, and behaving. An individual has a personality disorder when they display a lifelong pattern of pervasive problems in personality functioning, which cause difficulties in inter-personal relationships, leading to distress, poor social functioning and/or problems for other people. Various types of personality disorders (e.g. antisocial, borderline, narcissistic, paranoid, schizoid) are currently described in mental disorder classification systems: ICD-10 (World Health Organisation, 1992) and DSM-V (American Psychiatric Association, 2013).

There are numerous studies demonstrating high rates of personality disorder in offenders. Rates of personality disorder in any given population vary as a result of the

study method and definition used. In the general population, estimated rates vary from 4-11% (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2000). Within the prison population, rates vary from 10% (Gunn, Maden, & Swinton, 1991) to 78% (Singleton, Meltzer, Gatward, Coid, & Deasey, 1998). Fazel and Danesh (2002) in a systematic review of 62 studies from 12 countries found that 47% of male prisoners and 18% of female prisoners had Antisocial Personality Disorder.

Why is it important to understand personality disorders in Forensic Settings

Personality disorder has implications for risk assessment, treatment and management.

It is relevant to *risk assessment* as both personality disorder in general and certain types of personality disorder have been found to be related to higher rates of re-offending, i.e. antisocial personality disorder (Hanson & Morton-Bourgon, 2004; Bonta, Law and Hanson 1998) and psychopathy (Hemphill, Hare & Wong, 1998). In a meta-analysis of studies looking at the recidivism of sex offenders, Hanson & Morton-Bourgon (2004) found that antisocial orientation (antisocial personality disorder, antisocial traits, and history of rule violation) was the main predictor of violent non-sexual recidivism. In addition to deviant sexual interests, antisocial orientation, and specifically psychopathy, as assessed by the Psychopathy Checklist Revised (PCL-R) (Hare, 1991), were related to sexual recidivism as was the category of 'any personality disorder'. Antisocial orientation was also the most consistent predictor of general offending. Another meta-analysis (Bonta, Law, & Hanson, 1998) found that criminal history variables were the best predictors of future general and violent recidivism in both mentally disordered and non-mentally disordered offenders. In general, clinical variables had the smallest effect sizes, with psychosis having an inverse relationship with recidivism. However, antisocial personality was again found to be a significant risk factor.

Personality Disorder has remained as a Historical risk factor in the new version of the HCR-20-Version 3 (Douglas, Hart, Webster, & Belfrage, 2013). Whereas HCR-20 V2 had personality disorder and psychopathy as two distinct factors, version 3 has only one factor, entitled Personality Disorder, where a diagnosis of psychopathy would allow a rating of the factor but allows other personality diagnoses to elicit a positive rating on this item.

Since its development in the late 1970's, research has consistently shown that PCL-R psychopathy is associated with a high risk of recidivism and violent recidivism, including sexual recidivism. More recently there has been some criticism of the factor structure and individual items within the PCL-R, highlighting that many of the items measure behaviour rather than personality and therefore it is not surprising that it correlates well with future behaviour (Cooke, Michie, & Skeem, 2007). Some alternative measures of psychopathy have been developed and are undergoing research (e.g. Comprehensive Assessment of Psychopathic Personality (CAPP) (Cooke, Hart, Logan, & Michie, 2004) but the PCL-R still remains the dominant method in terms of assessing psychopathy and there is a significant research base behind it.

Personality Disorder is also relevant in risk assessment tools where personality disorder itself is not explicitly stated as a risk factor. For example, personality underpins many of the factors found in the Stable and Acute 2007 assessment; a dynamic risk assessment tool used with sex offenders. Ultimately, understanding personality is crucial to the development of a risk formulation: understanding how someone functions and from there working out how and why someone offends.

Personality Disorder is relevant to *treatment* as studies have shown that those with personality disorder have a poorer response to treatment and have been found to be more likely to disengage and drop out of treatment (Gunderson et al., 1989; Kelly,

Soloff, Cornelius, George, & Lis, 1992; Skodol, Buckley, & Charles, 1983). In order to benefit from treatment, treatment needs to be responsive to the patient's personality traits, i.e., the intervention needs to be tailored to the learning style, motivation, abilities and strengths of the offender (Bonta & Andrews, 2007).

With regards to *risk management*, it is relevant because personality will affect an offender's motivation and ability to engage with a risk management plan. Without understanding personality it is possible that a risk management plan includes strategies that are counterproductive or unlikely to work. Risk management does not take place within a vacuum and relies heavily on the relationship between supervisors and offenders/patients. Effective working relationships between the two are the foundations on which effective restrictions, monitoring and intervention can occur. A useful resource in recent years has been the Department of Health/Ministry of Justice document *Working with Personality Disordered Offenders* (Craissati et al., 2011) from England and Wales which is a practical guide and includes a breakdown by personality type of how to work with different personality presentations.

Issues in the Assessment of Personality Disorder

Diagnostic classification systems in Europe and North America have been undergoing review and update in the last few years. There was hope and expectation that there would be a change in the assessment and diagnosis of personality disorder based on research developments since the publication of DSM-IV and ICD-10. Initial publications from clinicians involved in both Working Groups appeared to back this up (Widiger, 2011). In DSM-IV and ICD-10 a number of different personality disorders were described. Each disorder had a number of traits associated with it and if, during assessment, the patient was found to have a certain number of these traits (this number changed depending on the specific personality disorder) then they met criteria for diagnosis.

Publications from the Working Groups of both diagnostic systems initially indicated a move to a dimensional approach which would allow assessors to consider the degree of impairment caused by problematic personality traits, i.e. no impairment, problematic personality, severe personality dysfunction (Crawford, Koldobsky, Mulder, & Tyrer, 2011). However, following disagreements within the DSM-5 working group (Frances, 2012) the new DSM-5 classification was published in 2013 with very little change from the DSM-IV diagnostic criteria of Personality Disorder. A hybrid categorical-dimensional proposal for diagnosing personality disorder was ultimately rejected by the DSM-5 Working Group on personality disorder but is included in the Appendix to encourage further research that might support this model. Using this alternative methodology, clinicians would assess personality and diagnose a personality disorder based on an individual's particular difficulties in personality functioning and on specific patterns of those pathological traits (American Psychiatric Publishing, 2013). ICD-11 was due to be published imminently, although this has now been pushed back until 2017, but is still expected to introduce a dimensional method of assessing personality disorder. Tyrer et al (2015) recently found that using the proposed ICD-11 classification system yielded higher levels of personality dysfunction than the ICD-10 model. They proposed this may be due to the age range of onset being more flexible. Overall they found it more useful in clinical practice as it allows for consideration of severity as well as traits.

In practice, individuals rarely fit neatly into the diagnostic categories and often meet criteria spanning different categories. When a clinician is considering personality disorder as a diagnosis they must consider the range of personality traits and the degree of severity. This is inline with the proposed ICD-11 classification model. Overall, when considering developing policies and procedures to address personality disorder it is important to realise that personality disorder is not one entity. Two patients with a personality disorder may require markedly different approaches and intervention to

address their problematic personality traits, not only because of the various combinations of traits that can make up a diagnosis, but also because the group of offenders with personality disorders are widely heterogeneous. Recent research has challenged the idea that personality disorders persist over time. Zanarini, Frankenburg, Hennen, and Silk (2003) found that in a sample of 362 in-patients with borderline personality disorder, 73.5% met the criteria for remission at six years follow-up. Sievewright**,** Tyrer, and Johnson (2002) followed up a group of 202 patients with a DSM-III neurotic disorder, dysthymia, panic disorder or generalised anxiety. When their personality status was re-assessed at 12-year follow-up using the Personality Assessment Schedule (PAS), the personality traits of the cluster B group had become significantly less pronounced whereas those in the Cluster A and cluster C group had become more pronounced.

Many patients in a forensic setting have no formal assessment of personality disorder. The main reason for this is likely to be the fact that a primary Personality Disorder is not considered a reason to detain someone in secure hospital care in Scotland (Darjee & Crichton, 2003). High rates of co-morbid personality disorder are found in offenders with mental illness (Blackburn, Logan, Donnelly, & Renwick, 2003) and learning disability (Hogue et al., 2006)**.** Assessment in secure care focuses on mental illness and learning disability. As described above, however, personality disorder has implications for risk assessment, treatment and management. Recent training events reflect a growing awareness of the importance of attending to personality issues. In England and Wales, where there have been in-patient Personality Disorder services in existence for more than ten years now (DSPD units), there has been a greater focus on patients with these diagnoses. However, it should be noted that there has been a recent shift in policy in England and Wales to treat and manage offenders with personality disorder in prison and Community Justice Services, while using hospital personality disorder units for individuals with co-morbidity. Psychologically Informed Planned Environments (PIPEs) have been developed as part of the joint Offender Personality Disorder Pathway Strategy (Joseph & Benefield, 2012) which will provide offenders with progression support following a period of treatment or a period in custody in preparation for their return to the community. Within this reorganisation of services, there still appears to be no consensus about which is the preferred treatment model. It is a 'joint' strategy as this new strategy conceptualises the responsibility for these offenders as a joint Justice and Health issue.

What is the Evidence-base for psychological treatment of Personality Disorder?

As stated above this paper does not constitute a systematic review of the literature. Therefore, it provides a summary of recent relevant literature without providing a detailed analysis on the quality of the research. The aim is to focus on the research evidence both to understand current service provision and to consider how services can develop in the future.

Finding an evidence base for psychological treatment for personality disorder is complex. The majority of the research literature on treatment of personality disorder focuses on borderline personality and more specifically on women who self-harm. There are clearly issues when trying to translate learning from this research to a forensic population that is predominantly male. Research into forensic populations and personality tend to focus on antisocial personality and psychopathy; the first because it is deemed to be prevalent and also relevant to reoffending, and the second because of its specific relevance to risk of violent reoffending. Very little of this research focuses on specific treatment of these disorders; rather it discusses the difficulties associated with the treatment of patients with these disorders (Looman, Abracen, Serin, & Marquis, 2005; Ogloff, Wong, & Greenwood, 1990; Seto & Barbaree, 1999; Skeem, Monahon, & Mulvey, 2002).

Personality Disorder treatment in the general population.
A systematic review of the effectiveness of psychotherapeutic treatment of personality disorder by Bateman & Fonagy (2000) found that there did appear to be evidence that that it was effective. The authors noted the following:

- There are issues about case identification, co-morbidity, randomisation, specificity of treatment and outcome measurement in the studies. Studies often did not adequately define or conceptualise personality disorders, were not clear about its distinction from other disorders, and did not adequately address the internal and external validity issues. This makes drawing conclusions about the impact of a specific treatment difficult, e.g., what did the treatment consist of, is it superior to no treatment or Treatment as Usual (which may vary between studies), has it merely reduced symptoms or effected a change in personality.
- Low numbers of research studies in this area.
- Commonalities between therapies that were shown to be moderately effective were:
    - well-focussed
    - devoted considerable effort to enhancing compliance
    - had a clear focus, e.g. problem behaviour or style of interpersonal relating
    - were theoretically considered highly coherent by both therapist and patient
    - relatively long-term
    - encouraged a strong attachment relationship between the patient and therapist
    - well-integrated with other services available to the patient.
- The evidence did not point to one type of intervention being superior to any other. It also did not point to a specific subtype of patient being suitable for in-patient, out-patient, or day-patient delivery of treatment.

(Bateman & Fonagy, 2000)

A more recent systematic review of psychological treatment for personality disorder (Lana & Fernandez-San Martin, 2013) highlighted some of the issues in trying to evaluate treatment in personality disorder research. It found great variation in the participants who do not enter treatment. This is largely attributed to the great variability in those who refused treatment but also the fact that exclusions criteria were not equally applied across the studies. There was also great variability depending on whether the developer of the therapy is also a co-author of the study – developers of a therapy tend to find their therapy works better than when non-developers conduct research on it. This may be down to enthusiasm and energy which overcomes adversity during a research study or it may be that they are more competent at delivering the therapy. Not all studies detailed the adverse events that they were interested in for the study making interpretation of results difficult. In this systematic review, MBT and DBT demonstrated the best results. DBT performed the best with respect to reducing suicides. MBT outperformed DBT for hospital admissions. Of particular note, the paper highlights that up to 40% of patients with BPD who request specific therapy may not benefit from it. Approximately 20% would not initiate treatment; and of those who initiate treatment 25% may not respond.

Issues around therapeutic allegiance have been consistently highlighted as a potential bias in psychotherapy research. Leykin and DeRubeis (2009) suggest that if it is not controlled for then it can seriously undermine the outcome of Randomised Control Trials (RCTs) in this area.

NICE Guidelines are available for the treatment and management of Borderline and Antisocial Personality Disorder. These are not developed specifically for forensic mental health services but their scope covers psychological treatment within these services. For

Borderline Personality Disorder, the guidelines highlight an 'explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user; structured care in accordance with the guideline; provision for therapist supervision'. It does not specify a particular treatment. For Antisocial Personality Disorder, the guidelines highlight that co-morbid conditions should be treated, particularly highlighting substance misuse, and in addition suggests that cognitive and behavioural approaches focussed on offending behaviours and other antisocial behaviour should be considered. It emphasises the need to develop an 'optimistic and trusting' relationship, autonomy and choice, and working on engagement and motivation.

The Matrix

Within NHS Scotland, significant work has been undertaken to produce *The Matrix* which outlines effective psychological therapies for different disorders. A separate Forensic Matrix was produced to reflect the specific therapies that are undertaken with forensic patients to address offending behaviour. Personality Disorder appears in *The Matrix* under Adult Mental Health with reference to the treatment of Borderline Personality Disorder. However within the Forensic Matrix it is acknowledged that many offenders have personality disorder and that, despite the fact that it is rarely the main presenting disorder, personality difficulties should always be assessed. It also underlines, as above, the importance of personality disorder in risk assessment treatment and management. It states:

"Psychological interventions for those with personality disorders should aim to: (1) help staff formulate, interact with and manage the patient (2) improve personality functioning through specific therapies; (3) reduce risk of re-offending through appropriately responsive offending behaviour programmes."

For Borderline Personality Disorder, *The Matrix* recommends CBT for Personality Disorder, Schema Focused CBT, Systems Training for Emotional Predictability and Problem Solving (STEPPS) (CBT Approach), Transference focused psychotherapy, DBT in secondary and specialist outpatient settings and Mentalisation Based Day Hospital for Day hospital settings (see Appendix 1). It should be acknowledged that the Matrix is not currently completely up-to-date as new research is constantly emerging.

Individual and Group Therapies for Personality Disorder

The problem of having a small evidence base to draw on when considering the best psychological treatment for personality disorder becomes even more acute when focusing solely on the forensic population. Historically, various committees and reviews have looked at the issue, (e.g., Reed report; Dolan & Coid, 1993) and come to the conclusion that this group is a difficult population to treat and that expectations of positive outcomes have to be realistic. Therefore the evidence base has to be taken from studies looking at the effectiveness of various treatments in the wider population as well as the forensic populations.

Recent training events in forensic settings in Scotland have focused on CBT for Personality Disorder, CAT and MBT. An overview of the main model-specific approaches to Personality Disorder can be found in Appendix 2 with reference to their potential application in, or relevance to, forensic settings.

Formulation

In recent years there has been convergence in the literature, where there seems to be growing agreement that all structured psychological therapies produce improvement in Borderline Personality Disorder (Bateman, 2012; Livesley, 2005). Formulation is the key process through which key areas of need and the relevant psychological techniques to address them can be identified.

Dr John Livesley, an international expert in Personality Disorder, has proposed a clinical approach to personality disorder that is eclectic. He does not propose that one therapeutic model is more effective than any other, a view currently supported by the literature, rather stating that there are common or generic change mechanisms (relational and technical) that all therapeutic models have, but also that each approach has techniques that can be beneficial when treating a patient. Formulation is highlighted as a key process in his approach to Personality Disorder. The model outlines principles for organising integrated treatment, core principles for working with personality disorder, and general treatment strategies for integrated treatment:

Table 1: Three principles for organising integrated treatment

1. Decompose personality disorder into its components and select appropriate interventions for each component
2. Conceptualize treatment methods in terms of:
    - General or generic methods
    - Specific treatment methods
3. Divide treatment into phases with different domains being treated during different phases

Table 2: Core Principles and General Treatment strategies for working with Personality Disorder

Livesley's core principles for working with personality disorder. There are five stages:	**Livesley's general treatment strategies for integrated treatment**
• Safety • Containment • Control and regulation • Exploration and change • Synthesis	1. Establish and maintain the structure and frame of treatment 2. Build and maintain a collaborative relationship 3. Maintain consistency 4. Promote validation 5. Build motivation 6. Encourage self-observation and self-reflection

By stating the principles and strategies for treatment when working with patients with personality disorder, this model allows a therapist to use any therapy that holds with these principles and strategies but also allows for experienced therapists to pick and choose specific therapeutic techniques from different therapies in order to treat specific aspects of the disorder, once they have formulated the case.

A psychological formulation can encompass the dimensional nature of personality and personality disorder. Ideally, formulations should be developmental and relational in nature and take into account early adverse relationships. Formulations should also be explanatory and predictive.

In line with Livesley's approach, it has been suggested that it is wise to have access to more than one type of therapeutic approach when working with personality disorder and this is referenced within the Matrix (Crawford et al., 2007).

Generalist Approaches to Personality Disorder

Recent developments in the treatment of personality disorder have highlighted the benefits of generalist approaches such as Generic Structured Clinical Care (SCC) and

Structured Clinical Management (SCM) (see below). In some of the RCTs, the control group has been more than a waiting list control. The control treatment has been structured clinical care that involves trained staff working with a formulation of the patient in an environment that is responsive to the patient needs. The patient group receiving this has often had similar outcomes to that of the treatment group. This has prompted some to look at the wider care that is being offered to patients with personality disorder, acknowledging that outwith 1:1 treatment or group treatment models there is a way of intervening and producing change that is more systemic and impacts on the therapeutic milieu.

Bateman and Fonagy's (2009) Structured Clinical Management (SCM) is one example of a generalist approach. It was developed as the control group treatment in an MBT RCT. The purpose was "to reflect best generic practice for borderline personality disorder offered by non-specialist practitioners within U.K. psychiatric services. Regular individual and group sessions were offered with appointments every 3 months for psychiatric review. Therapy was based on a counselling model closest to a supportive approach with case management, advocacy support, and problem-oriented psychotherapeutic interventions."(p.1357). In this RCT comparing SCM with Mentalisation-based Therapy (MBT) over 18 months in an out-patient setting, patients from both groups showed substantial improvements across a variety of metrics including functional outcomes (Bateman & Fonagy, 2013). There was steeper decline of both self-reported and clinically significant problems in the MBT group. For SCM the:

Aims of the intervention are to help the person to:

- Use services more effectively.
- Develop a better understanding of their own internal states of mind (internal states).
- Learn and practice skills to manage emotions/impulses/relationships more effectively.
- Develop activities outside of services (vocational).

Four foci are

- Interpersonal
  - Engagement in therapy by developing a therapeutic alliance despite the alliance being challenged by the interpersonal problems of the patient
- Impulsivity
  - Reduction of self-damaging, threatening, or suicidal behaviour
  - Rash decision making
- Emotional dysregulation
  - Emotional storms
  - Crisis demand
- Cognitive distortions
  - Interpersonal sensitivity especially to care personnel

Problem solving underpins core treatment strategies: mood management, emotion regulation, impulse control, interpersonal sensitivity, interpersonal problems, suicidality and self harm and management of risk. (Bateman, A., nd)

Within Chanen et al.'s (2008) RCT, both Cognitive Analytic Therapy (CAT) and 'Good Clinical Care' were found to have positive outcomes for patients. This differed from Clarke, Thomas, and James' (2013) RCT where CAT was found to be superior to Treatment as Usual on the NHS in group of patients with personality disorder. However on closer inspection these two control groups were not comparable. Chanen et al.'s 'Good clinical care' was a modular treatment package developed specifically for the study, described as akin to Linehan's 'treatment by experts' (Linehan et al., 2006) which

controlled for some factors believed to be effective in psychotherapy. It used a problem-solving model for all the patients and had optional modules for specific presenting problems, using cognitive behaviour techniques. The therapists involved in the control group received weekly external supervision from a Clinical Psychologist. An issue raised by this paper was whether the lack of superiority of CAT was due to the fact that the control group itself was a beneficial treatment. It was clearly not the equivalent of the TAU described in Clarke's paper which was similar to ongoing NHS care as required, the quality of which was not monitored during the study and varied by patient.

UCL has produced a competence framework for delivery and supervision of Psychological Therapies on serious mental illness – within which there is a competence framework for Personality Disorder (CORE, nd) (Appendix 3). Structured Clinical Care within this framework is not a direct alternative to specific psychological therapies but is instead seen as an option for patients who are struggling to engage with specific therapies. This document is detailed when it comes to outlining the competencies needed to provide structured clinical care. All staff involved in the provision of Structured Clinical Care are expected to have knowledge of personality disorders and understand the value and consistency of structured care (clear roles, consistency, etc.) and have the skills to: assess problems including clients' motivation for change and understanding of therapy; formulate problems; discuss the content of the intervention with the client; and develop a care plan. Implicit within this is that it is the responsibility of the whole clinical team to be aware of each patient's personality dysfunction, understand how it impacts on their behaviour and develop strategies for dealing with it. This has implications for the training of staff and supervision of staff.

In England and Wales the Knowledge and Understanding Framework was developed in England and Wales by the Department of Health and Ministry of Justice to support those working with people with personality disorder.

The key goal of the KUF is to improve service user experience through developing the capabilities, skills and knowledge of the multi-agency workforces in health, social care and criminal justice who are dealing with the challenges of personality disorder.

The multi-level educational package includes three levels of training:

- Personality disorder virtual learning awareness programme (*Raising Awareness*)
- Validated undergraduate degree programme (*Developing Understanding and Effectiveness*)
- Validated masters degree programme (*Extending Expertise, Enhancing Practice*)

An evaluation of the Level 1 training showed that immediately post-training staff showed an improvement in levels of understanding and capability efficacy and a reduction in negative emotional reaction. However at 3 months post-training, capability efficacy had reduced to pre-training levels, although emotional reaction and understanding levels were maintained. This indicated that ongoing support and supervision were required to consolidate skills (Davies, Sampson, Beesley, Smith, & Baldwin, 2014).

See Appendix 4 for Bateman and Krawitz's (2013) overview of the main components of the four generalist treatments that have been found to be effective.

Consultation to non-mental health staff

Another recent development in Scotland has been the creation of links between mental health services and agencies who are working with offenders in the criminal justice field, e.g. police and criminal justice social work. This work has been driven by the introduction of Multi-Agency Public Protection Arrangements (MAPPA) for Sex Offenders.

Around the country, psychologists and psychiatrists have offered consultation and assessment to agencies involved in MAPPA on issues related to personality disorder for sex offenders but in some cases also other types of offenders, e.g. those who perpetrate domestic violence and stalking. A clear focus to this work is to highlight personality disorder issues in order to understand their relationship with risk but also help staff develop ways of working with offenders that are likely to increase engagement as well as reduce risk. The most significant example of this is the NHS Lothian Serious Offender Liaison Service in South East Scotland (Russell & Darjee, 2013) but clinicians are offering consultancy on a more time-limited basis around Scotland which is funded specifically for this purpose.

Principles and Practices for working with clients with Personality Disorder.

Moore (2012) has proposed key principles and practices for staff working with clients with personality disorder that are likely to promote resilience in Personality Disorder services. These can be grouped into the areas of: Staff selection; Training; Support; and Responsive management. Briefly these principles state that:

- Staff selection should look at staff who are motivated and interested in working with clients who have interpersonal difficulties. Having enough senior staff in the service who have experience of working with complex disorders can be beneficial both in terms of having the right skill set but also providing role models to younger staff.
- Training should focus on how to work interpersonally with clients who push boundaries to help staff manage inappropriate interactions and set and maintain boundaries.
- Supervision provides a space through which boundary setting and maintenance can be discussed. Within group approaches to supervision, Reflective practice, Master classes and peer supervision are all given as examples.
- Responsive management includes learning from incidents through reviews. When incidents/crises are managed well then they can enhance resilience.

The Care Standards for Forensic Mental Health Inpatient Facilities in Scotland (Forensic Network 2005) emphasise relational security as central to the care of forensic patients. It "includes staffing, staff to patient ratios but also the provision of appropriate multi-disciplinary teams with the right range of skills and the availability of the right range of therapeutic activities. It relates to the formation of the therapeutic alliance between staff and patients based on a detailed knowledge of the patient. It is closely linked to risk assessment and risk management" (p.43).

Clinical Supervision

Clinical Supervision is a requirement for all practitioners who are providing psychological therapy in order to ensure adherence and monitor fidelity to a psychological framework, model or formulation. Most professionals and models are bound by statutory obligations to ensure their work is adequately supervised e.g., to the GMC, BPC, Royal College of Psychiatrists, Health and Care Professions Council.

Moore (2012) outlines the main functions of supervision: it is formative (lifelong learning and professional development); restorative (a space for support, shared understanding and an acknowledgment of impact of the work) and normative (focused on good practice standards) Boundaries and limits are 'flexible standards of good practice' and involve the application of professional judgement (Moore, 2012). Duggan (2005) highlights that the exchanges between patients with personality disorder and staff can be 'covert' so having a safe place to discuss appropriate responses is crucial.

Within the frame of treatment, there are particular issues in relation to working with personality disorder patients due to the nature of their relational disturbances and impacts on others. Professionals can unconsciously become caught up in enacting problematic relational patterns with patients that might lead to boundary slippage or even violation. It is useful to be able to consider transference and counter-transference issues and to maintain awareness of fatigue and frustration when working with this complex patient group. Therefore clinical supervision provides a safe place for staff to describe and discuss how best to respond to such challenges.

The need for supervision is highlighted in a number of key documents including the Competence Framework for Psychological Interventions for People with Personality Disorders (Roth & Pilling, 2008) the Standards for Medium-Secure Units (Tucker & Hughes, 2007), NICE Guidelines for Antisocial (NICE, 2009a) and Borderline (NICE, 2009b) as well as many others.

Reflective Practice

Alongside supervision, reflective practice is now regarded as a crucial component of psychological work. The purpose of reflective practice is to allow a safe, contained and boundaried space for staff to discuss the difficulties they face in engaging with their work. In recent years, reflective practice has taken place not just for individuals but for teams or groups of staff together. It can focus on relational, systemic, procedural or other issues.

When working with patients with personality disorder, staff can lose the objectivity that is vital in the care and treatment of this group of people as they can, by the nature of their complexity and diagnoses of personality disorder, lead clinicians to lose theirs. In a number of public enquiries, this problem has been implicated in difficulties for teams (Mental Welfare Commission for Scotland, 2009), units (Blom-Cooper, 1995) and their patients. Reflective Practice is one way in which objectivity as well as empathy can be preserved.

Reflective Practice is also intended to be a supportive situation and might be seen as one of the ways of meeting the Intensive Staff Support requirements of both the ASPD (NICE, 2009a) and Borderline Personality Disorder (NICE, 2009b) guidelines.

It may be important to consider when setting up reflective spaces that the facilitator may be more effective if they can hold an objective position in relation to other disciplines - most helpfully the position of being either an outsider to the institution or someone who can remain apart from other disciplines/teams. Additionally, the reflective facilitator should have the ability, and training, to understand and tolerate the counter-transference demands of a forensic environment. The Royal College of Psychiatry has recommended access to an accredited psychotherapist with forensic experience in both its Psychotherapy Standards for Psychotherapy within Medium Secure Services (Jacob and Macallister (2012), and their College Report on Psychological Therapies in Psychiatry and Primary Care (RCPsych, 2008) in order to support assessment, supervision, consultation, training and reflective practice.

Therapeutic Milieu (Environment)

Having a therapeutic milieu, or environment, that is cognisant of personality issues is one step towards increasing the psychological safety for patients and staff. Relational Security has become a core tenet of secure settings and is well described in the See, Think, Act documentation (DOH, 2008) and illustrates the importance of staff being interpersonally aware of their environment to manage risk and day-to-day work with complex patients –as well as ensuring that staff try to look after themselves. The work

around generalist approaches is about laying out a model for staff training that encourages an appropriate therapeutic milieu for clients with personality disorder.

Within the PIPEs in England, staff receive training to develop an increased psychological understanding of working with offenders on the basis that this will allow staff to build safe and therapeutic environments from which to facilitate offenders' progress in treatment and allow adequate opportunities for the testing of new learning. Staff training is based on the Personality Disorder Knowledge and Understanding Framework (Joseph and Benefield, 2012).

The Treatment Readiness Literature has both highlighted personality factors as being a barrier to engagement in treatment but also the context and environment in which treatment takes place (McMurran & Ward, 2012).

In forensic work in Scotland, a number of developments have been started in relation to creating a more therapeutic environment for patients or prisoners. A proposal to use MBT principles for staff at The State Hospital has been written and been well-received and further pilot work in NHS Fife's Low-Secure Service is beginning. This is in conjunction with ongoing work at Willow and the women's service at HMP-Edinburgh; again, all utilizing a mentalising framework to try and improve the interpersonal environments of forensic settings. Within the Orchard Clinic, training has been available clinic-wide on CAT-informed team work to augment individualised CAT treatment offered to suitable patients. Psychology staff provide ward-based 'CAT chats' for ward staff with the aim of providing formulations of complex issues. It has provided a safe space for staff to discuss complex issues and feedback suggests it is one approach to reflective practice. A recent evaluation demonstrated a positive shift in staff attitudes to patients following these CAT chats.

Conclusions

With only a very limited evidence base to draw on, it is difficult to draw firm conclusions about the effectiveness of interventions for people with personality disorder in forensic settings. Never-the-less, there is sufficient guidance in the literature and from local practice to develop recommendations for services which are most likely to lead to the successful management of this population.

The current consensus is that there is no one therapy that is superior to any other. Moreover, the availability of more than one form of therapy is recommended due to the complexity and range of personality dysfunction. In addition to the above consensus, there is an acknowledgement that a psychological formulation is critical not just to understanding the nature of the personality dysfunction but to drive the therapeutic approach and relevant techniques to use for each patient. Recent research has found that generalist approaches, involving staff specifically trained in personality disorder, can be beneficial, particularly for those patients who struggle to engage with individual or group therapy. Generalist approaches (see Appendix 4) have the potential to work in two ways: to provide a secure base from which individual therapy can then build; or as an alternative to individual or group therapy when patients fail to engage. In recent years in Scotland there has been an increase in training events focusing on therapeutic approaches to dealing with personality disorder and this is to be welcomed. Within forensic services, given the high rates of personality disorder, there is a need to have staff of all disciplines trained in awareness, identification, assessment and treatment of personality dysfunction. When considering the treatment of personality disorder, there should be a focus on the importance of therapeutic milieu and not just on the value of individual or group therapy. A key consideration is to ensure that the care being provided is not making things worse. If the milieu is not responsive this will have a negative effect for the patient but also for staff through stress, burnout or using resources inappropriately.

Recommendations

Recommendations that follow from the above conclusions:

1. Basic awareness training in working with patients with personality disorder is rolled out to all staff in secure services. This is currently already being done in some settings and, depending on who is providing the training, this will be rooted in a specific therapeutic model. However opportunities identified to achieve this are through the New to Forensic Programme and online learning via the Learnpro system. A new Learnpro module based on *Working with Personality Disordered Offenders* (Craissati et al., 2011) is currently being developed and should be considered for inclusion in mandatory training. There is a clear need for this for clinical staff; however there is also a need for low-level training for non-clinical staff as administrative and domestic staff regularly come into contact with patients with personality disorder and personality issues. In addition, the Relational Security Module through Learnpro should also become part of mandatory training. In the future this should be a core aspect of induction training in Forensic services.

2. Training is provided to both staff and managers on the importance of therapeutic milieu and consideration is given to structured clinical care in relevant settings.

3. Where the concept of generalist approaches are adopted, further training in personality disorder should then be provided that develops the concepts introduced in the awareness training and allows for staff to enhance their knowledge base and practice different recommended strategies for dealing with difficult staff/patient interactions, e.g. training involving role play and problem-solving around 'real' cases.

4. A psychological formulation is key to both understanding the development of a patient's personality dysfunction and to developing an individualised plan for mental health care and risk management, one which focuses on personal interactions between staff and the person. Psychologically informed management is beneficial for patients, in that it enhances their ability to engage and benefit from therapeutic approaches and care, and beneficial for others because it directs resources effectively and ultimately reduces the risk.

5. When staff are working with patients with personality disorder there is a clear need for clinical supervision and/or reflective practice. Those providing clinical supervision and facilitating reflective practice need to have the relevant competencies and given that we are dealing with a forensic population this would include 'forensic competencies'/awareness of forensic issues and forensic environments. Each secure setting needs to consider how best to provide reflective practice. Different models have been applied already, both external and internal, and both appear to be of benefit.

6. Each secure setting should be able to provide specific psychological treatment for personality disorder, group or individual, when required. Ideally, there should be an ability to provide more than one type of therapy so that each patient has the opportunity to access a therapy that is most suited to their needs and interpersonal style.

7. Forensic Clinical staff should be available to provide consultation to non-mental health staff, e.g. social work, on forensic cases where personality problems are an

issue, and to mental health staff working with difficult clients, some of whom may have a history of offending or aggressive behaviour, e.g. adult mental health services, Intensive Psychiatric Care Units, rehabilitation wards, etc. This is an efficient use of limited expert clinical resource, has the potential to provide early intervention to prevent a later admission, and allows for the appropriate allocation of resources. A number of models outlining how this is provided have been proposed, varying from services located in each health board to a regional service to a national service (proposals provided by the Serious Offender Liaison Service to Scottish Government).

It is proposed that there are certain requirements for services that are related to the extent to which they are dealing with a group of patients that have personality difficulties, dysfunction, or disorder. For all forensic settings it is expected that they would meet the following minimum service requirements -

Minimum service requirements for all forensic settings:

1. Personality disorder awareness training for all clinical staff such as New to Forensic, New to Essentials of Psychological Care, as appropriate as set out in these documents, and the new Learn Pro module on Working with Personality disordered Offenders
2. Personality disorder awareness training for non-clinical staff, such as New to Forensic, as appropriate as set out in these documents.
3. Assessing personality functioning alongside other mental health disorders, taking into account the shift in the research literature (and potentially classification models) from categorical to dimensional models of personality disorder assessment.
4. The ability to provide more than one highly specialist psychological therapy for patients with personality dysfunction or disorder
5. Supervision and reflective practice for staff who provide psychological therapy
6. Providing consultation to staff and teams working with those who have personality dysfunction/disorder and provide management advice to other NHS staff in non-forensic settings.
7. Risk management that is psychological informed – i.e., that takes into account personality functioning, its impact on risk, and how that affects supervisory relationships
8. Reflective practice for all ward staff
9. Access to a psychotherapist, who has competencies relevant to forensic mental health, to provide reflective practice and supervision.
10. Significant Incident Reviews (or their equivalent) – when and if they need to occur, should be reflective rather than interrogative, using peers as well as external facilitators. There are likely to be complex interrelationships that are relevant to the understanding of untoward incidents and an inclusive process enhances the likelihood of good learning outcomes. Staff need to be supported throughout this process as this will enhance resilience going forward.
11. Staff selection procedures that explicitly encourage the employment of staff who are willing and/or can demonstrate the ability to work with patients with interpersonal difficulties, e.g. using work-based scenario exercises to allow applicants to demonstrate their interpersonal abilities in difficult situations. It is assumed that within the NHS Values Based Recruitment approach, this will already have been addressed.

Additional minimum requirements for forensic inpatient settings are:

- A milieu that is responsive to the needs of the personality disorder clients – including generalist approaches such as Structured Clinical Management or similar (see Appendix 4)
- A Psychological formulation of each patient that incorporates their personality functioning

It is acknowledged that in providing the above minimum requirements then a service is meeting a significant amount of the patients needs with regards to personality dysfunction. In addition, services may wish to consider:

1. Each patient has a formal assessment of personality during the admission process to an inpatient facility in order that all staff are aware of the potential difficulties they may face in their interactions with the patient. A detailed assessment process was outlined in a previous Forensic Network personality disorder paper (Thomson et al, 2005).
2. Specialist training for staff on Personality Disorder and Personality Dysfunction., e.g. enhancing understanding of different personality presentations, the impact on ward dynamics, staff morale and therapeutic relationships, providing opportunities to role play different ways to deal with difficult staff-patient interactions. This training could be developed locally or could be taken on for developmental at a national level by the Forensic School and/or NES.
3. Providing consultation to staff and teams working with those who have personality dysfunction/disorder and provide management advice to other non-NHS services working with personality disordered offenders
4. Community teams should have formulations for patients that are being managed by the team. In situations where patients are referred for assessment and then discharged or passed on to other teams, it may be unreasonable for all cases to expect that a psychological formulation is undertaken although assessment by forensic teams may provide an important point in patients' care pathways to undertake formulation.

In submitting this to the Forensic Network Board, it is respectfully recommended that the above are considered for inclusion in the High, Medium and Low Secure Care Standards.

Please see appendix 5 for the proposed implementation plan.

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APPENDIX 1

Borderline Personality Disorder

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Severe	Secondary/ Specialist Outpatient	High	CBT for personality disorders Individual therapy (30 sessions over 1 year)	A[2]
			Schema Focused CBT Twice weekly over 3 years	A[3]
			STEPPS -Systems Training for Emotional Predictability and Problem Solving (CBT approach) 20 group sessions group + usual treatment	A[6]
			Transference-focused psychotherapy (twice weekly sessions plus weekly supportive treatment over one year)	A[4]
			Dialectical Behaviour Therapy (DBT) Involves group + individual therapy + telephone support (Several times per week over one year)	A[1]
Severe	Secondary/ Specialist Partial Day Hospital	High Multi-modal	Mentalization based Day Hospital (Several times per week over 3 years)	A[5]

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Lessons learned from the evaluation of pilot services in England suggests that due to the complexity of personality disorder most services should offer more than one type of intervention (Crawford et al, 2007)[7].

APPENDIX 2

Cognitive Behaviour Therapy (CBT)

Description
Cognitive Behavioural Therapy (CBT) is based on the cognitive theory of psychopathology which states that our emotions and behaviours are driven by our perceptions and spontaneous thoughts about situations. These perceptions and thoughts can often be problematic and dysfunctional leading to distress or problematic behaviour. CBT uses a combination of behaviour and cognitive techniques to address problem behaviour through identifying the spontaneous thoughts and correct the dysfunctional thinking. It is problem-focussed and action-oriented. Research has shown it to be effective in a number of Axis 1 conditions ranging from anxiety and depression to psychosis.

Overview of Evidence
Professor Kate Davidson, Consultant Clinical Psychologist, has developed a model of Cognitive Therapy for Personality Disorders (Davidson, 2007). This has been evaluated in a range of studies ranging from case series (Davidson & Tyrer, 1996) to RCTs for Borderline Personality Disorder (Davidson et al., 2006) and Antisocial Personality Disorder (Davidson et al., 2009). The BOSCOT RCT for BPD found a reduction in self harm and this was maintained at six year follow-up (Davidson, Tyrer, Norrie, Palmer, & Tyrer, 2010). Over half of the participants no longer met criteria for BPD at six year follow up. The MASCOT trial found a reduction in aggression, alcohol misuse, and improvement in social functioning and more positive beliefs about others for those who received CBT compared to TAU. These evaluations have been of individual therapy.

CBT for Personality Disorder has now been adopted and adapted for use by the Chromis Programme within the Dangerous and Severe Personality Disorder (DSPD) units in England. Chromis is described as "An accredited intervention that aims to reduce violence in offenders whose level or combination of psychopathic traits disrupts their ability to engage in treatment and change". The majority of men on the programme have a PCL-R score over 25 and around half have a PCL-R score of 30 or above.

The majority of articles published from the team evaluating Chromis have related to the issues around setting up the programme, and the challenges in evaluating it (Tew & Atkinson, 2013). One paper has reported that participants have shown lower rates of physical aggression both in treatment and after leaving treatment but higher than expected rates of verbal aggression (Tew, Dixon, Harkins, & Bennett, 2012). To date there are no articles providing a comprehensive evaluation of the programme. Tew and Atkinson (2013) outline the substantial programme of staff development that has been put in place for the prison officers that run the programme in order to ensure adequate training and supervision and to prevent burnout.

Training
Training was recently provided by Professor Kate Davidson to a group of Forensic Clinical Psychologists from across the Forensic estate in Scotland. This training focused on CBT for Personality Disorder as an individual therapy. There are ongoing discussions around peer supervision for those who attended training and who intend to use it.

On a more general level, staff can receive training in CBT through CBT Certificates, Diplomas and Masters qualifications. This is not specific to personality disorder and will focus more on neurotic disorders. However it provides staff with an awareness of the CBT model and some or many of the relevant techniques.

Expected Outcome of Therapy
Through participating in this therapy the intended outcome would be that the patient would have an understanding of how certain problematic beliefs and behaviours have developed over time. Through therapy the patient will work to develop more adaptive and positive ways of thinking and behaving.

Benefits
The benefits of this approach are that many clinicians are trained in CBT and there is a level of awareness about CBT principles throughout mental health staff as a whole. It should be noted that CBT for Personality Disorder has some specific aspects that may not be covered in some generic training courses. However staff trained in CBT techniques could treat discrete areas of difficulty that someone with personality disorder has, e.g. symptoms of anxiety or depression

Limitations
Traditional CBT is focused on intrapsychic processes and therefore it may be harder to think about relational problems. Some clients find it hard to identify dysfunctional thinking and can find the cognitive aspect difficult, i.e. lack of awareness of their thought processes. In recent years, CBT has started to engage with more of the emotional and relational aspects of functioning.

Cognitive Analytic Therapy (CAT)

Description
Cognitive Analytic Therapy (CAT) is a time-limited psychotherapy informed by cognitive therapy, psychodynamic psychotherapy (specifically object relations) and developments in dialogical thinking. CAT is an interpersonal (or relational) therapy that focuses on repeating patterns in relationships. Although the literature on CAT initially developed within adult mental health settings in the early 1980's it started to focus on personality disorder, particularly borderline personality disorder.

Overview of Evidence
CAT has a range of research literature to support its use with Borderline Personality Disorder; some of which finds it to be equivalent to other therapies in treating borderline personality disorder; others find it superior to a control group (Chanen et al., 2008; Clarke et al., 2013). However some of these RCTs raise the issue of the quality of the TAU or control group provision (see above). Traditionally CAT was developed as an individual therapy but now offers a general theory that can be applied to a range of settings and presenting problems. Recent developments in CAT have been about using the CAT formulation in a contextual way to understand not just the behaviour of the patient but the staff and team's behaviour towards a patient, to understand how problematic behaviours are repeated over time (Kirkland & Baron, 2014). In 1:1 therapy, the formulation is explicitly shared with the patient through the writing of a letter and will explicitly discuss the potential problems that may arise in the patient-therapist dynamic. The techniques used once the treatment phase has started are a range of cognitive and analytic techniques depending on what the problem behaviour is. CAT was specifically developed as a time-limited therapy for use in NHS settings and this is seen as one of its benefits.

Training and Application
Within Scotland, NES has offered a 5-day CAT course for those interested in using CAT in forensic settings. A CAT practitioner needs to complete a 2 year diploma accredited by The Association for Cognitive Analytic Therapy (ACAT) and supervision groups are the preferred method of supporting practice. A 6-month CAT skills certificate (aimed at staff teams utilising CAT informed work) is also offered in some areas. 2-day introductory trainings are offered throughout the UK. The 5 day training has had over 120 staff attend over the past 6 years and feedback is overwhelmingly positive. The Orchard Clinic

in addition to 1:1 CAT therapy uses CAT informed thinking (contextual) with staff teams for those patients who exhibit problematic behaviour. This involves meeting regularly with ward staff to discuss ongoing problems, develop a formulation which includes the staff and patient dynamics, and provide reflective supervision. The number of CAT Practitioners required would depend on the size of the clinic. CAT consultancy is also an application of CAT that has been described (Carradice, 2012). This is promoted as an option where there are clients who are deemed unsuitable for individual psychotherapy or for whom poor outcomes would be predicted. This is currently offered within the SOLS service based in Lothian and Borders CJA.

Expected Outcome of Therapy
CAT is time limited and the expectation is that, although some improvement may be seen during therapy, much of the improvement will be seen post-therapy and that the client will take their learning and use it as they go forward in life. Clients can return for further therapy down the line but each 'dose' of therapy will be time-limited and the end date will be explicit. The aim is that the patient gains a clearer understanding of the difficult relationship dynamics they have in their life (this could be intra-personal relationships, interpersonal relationships or both), how they have developed and how they repeat throughout their life. With this knowledge the client can be more aware of difficult situations and proactively think about how they will act and respond.

Benefits
The benefits of CAT are that it has been specifically developed as a time-limited therapy; there are publications outlining the ways in which it can be integrated into the milieu of the ward/clinic/institution (Kerr, 1999; Mitzman, 2010; Shannon, 2009). It has been designed specifically for personality problems and the relational framework has a direct application to dynamics with staff teams and between staff and the people they work with, such as those with personality disorders.

Limitations
The limitations are that the training to be a CAT Practitioner is a 2-year process and there are limited numbers of Accredited CAT Practitioners within Forensic Services. Clinical Governance may therefore be an issue. There is a small but growing evidence base. It has not been developed as a group therapy.

Dialectical Behaviour Therapy

Description
DBT is a specific type of cognitive-behavioural psychotherapy developed in the late 1980s by psychologist Dr Marsha Linehan to improve the treatment of chronically suicidal patients with borderline personality disorder. DBT is a cognitive-behavioural approach that emphasizes the psychosocial aspects of treatment. The theory behind the approach is that some people are prone to react in a more intense and out-of-the-ordinary manner toward certain emotional situations, primarily those found in romantic, family and friend relationships. The theory behind DBT suggests that some people's arousal levels in such situations can increase far more quickly than the average person's, attain a higher level of emotional stimulation, and take a significant amount of time to return to baseline arousal levels.

Overview of Evidence
There is a significant body of research around DBT including RCTs (Linehan, Armstrong, Suarez, & Allmon, 1991; Linehan et al., 1999; Linehan et al., 2006; McMain et al., 2009) evidencing its effectiveness in patients with borderline personality disorder, suicidal behaviours and co-morbid drug problems.

Training and Application
Training in DBT to become an accredited therapist can take 2 years. DBT awareness courses are available as are DBT skills training. DBT as described in the manual involves group and individual therapy as well as 24-hour phone support. In practice DBT tends to involve group and individual therapy.

Expected Outcome of Therapy
The outcome of DBT is expected to be reduced frequency and a lower severity of self injurious behaviour in addition to improved ability to manage emotions.

Benefits
DBT Skills groups have been run in some secure units in Scotland particularly targeting those with self-injurious behaviour. It is often regarded as the treatment of choice for patients with serious self harm. Some within the literature suggest that it is a treatment for self harm rather than for borderline personality disorder. Treatment as described by Linehan normally comprises both individual and group therapy.

Limitations
The cost and intensity of training may be an issue in terms of implementing DBT and it is resource intensive.

Mentalisation-Based Therapy (MBT)

Description
Mentalisation Based Therapy (MBT) is a therapy that aims to improve patients' capacity to 'mentalize' – Mentalizing is the process of holding your own mind in mind, whilst also attending to what may be going on in the mind of others. The MBT model focuses on interpersonal relationships as they impact on this capacity in all of us. Failing to mentalize leads to marked difficulties in maintaining self identity, affect regulation and impulsivity – both important precursors to acts of aggression to self or other. MBT was specifically developed with personality disorder in mind, particularly BPD.

Overview of Evidence
MBT is a more recent development than the other therapies being discussed. It does have a growing body of research, including RCTs (Bales et al., 2012; Bateman & Fonagy, 2009; Jorgensen et al., 2013). The original study, based on a partial hospitalisation model, was published in 1999. MBT has again been developed and evaluated mainly with patients with BPD. Of interest to those working in forensic populations, however, is that latter research papers have not excluded patients with antisocial personality disorder and have shown that MBT becomes even more effective with patients with multiple comorbid personality disorder diagnoses (Bateman & Fonagy, 2013).

MBT was found to be superior to standard psychiatric care for patients with BPD at the 6-month point of treatment and gains were sustained for the further 12 months of the programme (Bateman & Fonagy, 1999). At 18-month follow-up those who completed the partial hospitalisation programme maintained their substantial gains and showed statistically significant continued improvement on most measures with concurrent improvement in social and interpersonal functioning. A further follow-up study found that 5-years post-discharge, the MBT group continued to show statistical superiority on measure of suicidality, BPD diagnostic status, service use, use of medication, global functioning; and vocational status (Bateman & Fonagy, 2008).

As mentioned above, Bateman & Fonagy carried out a further RCT comparing MBT and Structured Clinical Management (SCM) which reflects best generic practice for BPD. Both groups received 18 months of treatment and equivalent supervision. Both groups showed improvements on all outcome variables but patients in the MBT group showed a steeper decline in both self-reported and clinically significant problems including suicide

attempts, severe self-harm and hospitalisations. Other studies have found similar findings (Bales et al., 2012; Jorgensen et al., 2013).

Expected Outcome of Therapy

The aim of MBT is to improve the patient's ability to 'mentalise', i.e. be aware of their own minds and that other people may have different minds to theirs. A positive outcome would therefore be an increased ability to mentalise which, it is hypothesised, will enhance the patient's ability to manage complex interpersonal and social situations and relationships. MBT has a range of techniques which the therapist uses to work with the patient's style of thinking and feeling, which has been identified as unhelpful. These techniques seek to encourage the patient to reflect on the assumptions they make about others that may result in problematic and harmful behaviour, either to themselves or others. Given that the patient has had lifelong difficulties with this then it would be expected that there would be gradual improvement over time, as they have a chance to develop their new skills.

Training

As a result of the training provided by NES, there has been an opportunity for over 150 staff across the Forensic Network to attend the two-day skills training in MBT. This training has focused on the techniques that MBT uses with patients who have 'mentalising' problems and has not focussed on formulation or the delivery of MBT as a formal treatment programme. Fewer staff have attended the Practitioner training and there may be an issue about the clinical governance of the application of MBT techniques by those who have attended the skills training. MBT Scotland is the formal body linked the NES and the Anna Freud Centre to oversee governance and training issues nationally and has sought to address governance issues for those who have been Skills trained through case consultation groups

Benefits

MBT has been developed specifically for the management and treatment of personality disorder. Given that there is an increased awareness of MBT within all staff groups, there are opportunities for MBT techniques to be used on a day-to-day basis by ward-based staff who are dealing with patients' daily relational difficulties. MBT does not therefore need to be limited to individual or group sessions with a therapist. For the latter a clinical formulation identifying mentalisation as a core issue is crucial. For ward-based staff, there are also issues around the awareness of the patients on the ward where mentalising problems form part of the clinical formulation so that MBT skills are used appropriately. A number of studies have shown the MBT approach to be effective with clinical staff in improving attitudes to patients with personality disorder (Polnay, 2015), which is correlated with less burn out and less absence in staff (Bowers, 2000); and MBT-Skills training also promoted empathic responses to patients with personality disorder (Warrender, 2015). The latter also found the skills to be "useable".

Limitations

The limitations are that it is not clear if all patients with Personality Disorder require help with mentalising; though it is hoped that patients with Cluster B Personality Disorder diagnoses and those with more paranoid personality disorders will be suitable for treatment. MBT was initially developed within a partial day-hospital programme and was intended to be a longer tem therapy, e.g. 18 months. It has been modified for outpatient settings where treatment is likely to be less intensive and possibly of a shorter term and its effectiveness in these setting is being investigated. It maybe though that less intensive treatment may be beneficial for patients with significant attachment disturbance as it lessens the impact of therapists activating a system in patients that is dysfunctional. Less may be more. Studies so far have shown reasonable outcomes but some patients still remain impaired at 18 months (Bateman, Ryle, Fonagy & Kerr, 2007), as is the case with virtually all studies examining treatment of Personality Disorder.

Other treatments in the Matrix.

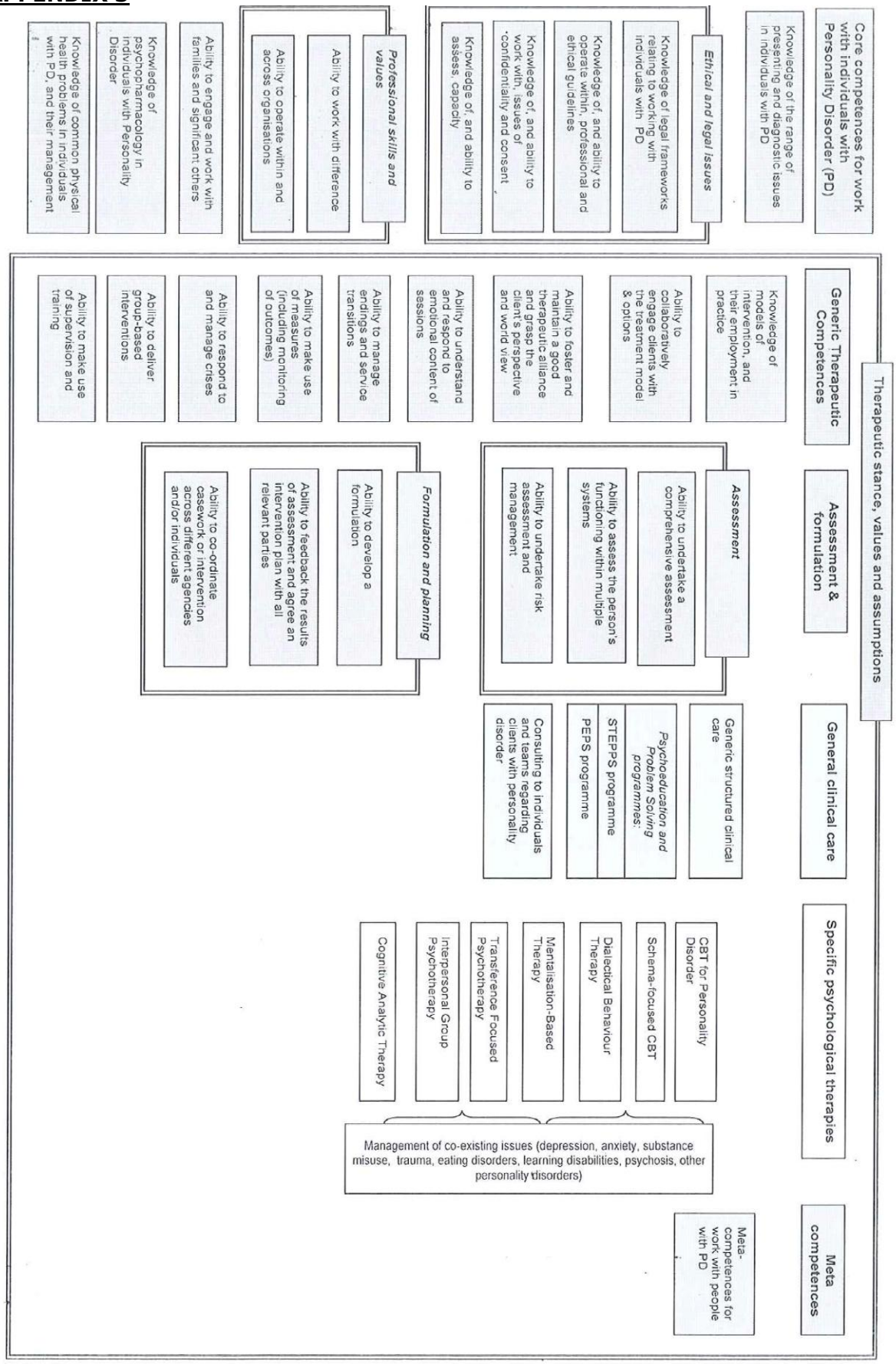
As stated above, this paper is focusing on the therapies where recent training has been provided for forensic mental health professionals in Scotland. There is an evidence base for other psychological therapies and a brief summary is given below.

Schema focused CBT is a type of cognitive therapy developed by Jeff Young (Young, 1994; Young, Klosko, & Weishaar, 2003). Research has been supportive of its efficacy with personality disorder in smaller studies although would benefit from more research (Masley, Gillanders, Simpson, & Taylor, 2012). Introductory training is available. However in order to become an accredited Schema Focused Therapist, intensive training is required followed by specific supervision. This has inhibited the roll out of this as a viable treatment option in non-forensic settings. The Matrix recommends twice weekly sessions over 3 years for SFT whereas CBT for Personality Disorder is recommended at 30 sessions over a year. Bernstein, Arntz & de Vos (2007) have highlighted the difficulties associated with using SFT in forensic settings including the need for intensive supervision, particularly when beginning to use SFT and the need for prior experience of psychotherapy.

Systems Training for Emotional Predictability and Problem-Solving (STEPPS) has been found to be superior to treatment as usual in a 1-year follow up study in the USA (Blum et al., 2008). It is a manual based treatment developed as a supplement to existing psychiatric treatment. It consists of weekly 2-hour seminars over 20 weeks. It has three main components: psycho-education about borderline personality disorder, emotion management skills training, and behaviour management skills training. The systems component seeks to educate friends, family and carers about how to best interact with the patients.

Transference-focused psychotherapy is based on contemporary psychoanalytic theory and particularly on Kernberg's object relations model of borderline personality disorder (Kernberg, 1976). It is a highly structured twice-weekly therapy. There are two RCTs that support its use with borderline personality disorder. Doering et al. (2010) found it to be superior to treatment by a community psychotherapist in the domains of borderline symptomatology, psychosocial functioning, and personality organisation. There were also preliminary indications that it was superior in reducing suicidality. Clarkin, Levy, Lenzenweger, & Kernberg (2007) compared TFP, DBT and dynamic supportive treatment in outpatients with borderline personality disorder over a year. All three treatments were associated with improvements. TFP brought about the most amount of change, i.e. change in multiple domains whereas DBT and supportive psychotherapy were associated with fewer changes.

APPENDIX 3


Core competences for work with individuals with Personality Disorder (PD)
Knowledge of the range of presenting and diagnostic issues in individuals with PD
Ethical and legal issues
Knowledge of legal frameworks relating to working with individuals with PD
Knowledge of, and ability to operate within, professional and ethical guidelines
Knowledge of, and ability to work with, issues of confidentiality and consent
Knowledge of, and ability to assess, capacity
Professional skills and values
Ability to operate within and across organisations
Ability to work with difference
Ability to engage and work with families and significant others
Knowledge of psychopharmacology in individuals with Personality Disorder
Knowledge of common physical health problems in individuals with PD, and their management
Therapeutic stance, values and assumptions
Generic Therapeutic Competences
Knowledge of models of intervention, and their employment in practice
Ability to collaboratively engage clients with the treatment model & options
Ability to foster and maintain a good therapeutic alliance and grasp the client's perspective and world view
Ability to understand and respond to emotional content of sessions
Ability to manage endings and service transitions
Ability to make use of measures (including monitoring of outcomes)
Ability to respond to and manage crises
Ability to deliver group-based interventions
Ability to make use of supervision and training
Assessment & formulation
Assessment
Ability to undertake a comprehensive assessment
Ability to assess the person's functioning within multiple systems
Ability to undertake risk assessment and management
Formulation and planning
Ability to develop a formulation
Ability to feedback the results of assessment and agree an intervention plan with all relevant parties
Ability to co-ordinate casework or intervention across different agencies and/or individuals
General clinical care
Generic structured clinical care
Psychoeducation and Problem Solving programmes:
STEPPS programme
PEPS programme
Consulting to individuals and teams regarding clients with personality disorder
Specific psychological therapies
CBT for Personality Disorder
Schema-focused CBT
Dialectical Behaviour Therapy
Mentalisation-Based Therapy
Transference Focused Psychotherapy
Interpersonal Group Psychotherapy
Cognitive Analytic Therapy
Management of co-existing issues (depression, anxiety, substance misuse, trauma, eating disorders, learning disabilities, psychosis, other personality disorders)
Meta competences
Meta-competences for work with people with PD

Appendix 4

Table 2.1 Commonalities across effective generalist treatments

	SCM	GPM	GCC	SP
Topics discussed in chapter text				
Starting therapeutic stance				
Voluntary, enthusiastic, hopeful and welcoming clinicians	Y	Y	Y	Y
Organization willingness	Y	Y	Y	Y
Therapy relationship				
Therapeutic alliance	Y	Y	Y	Y
Treatment goal consensus	Y	Y	Y	Probably
Collaborative agreement on how to achieve agreed upon goals	Y	Y	Y	Probably
Empathy and validation	Y	Y	Y	Y
Treatment model features				
Well-structured treatment	Y	Y	Y	? Moderately
Active therapist	Y	Y	Y	Modestly active
Regularly scheduled sessions for adult treatments	Y	Y	N/A	Y
Clinician monitoring and quality assurance	Y	Y	Y	Y
Treatment model that one believes in, has clear focus, and is theoretically principled and coherent	Y	Y	Y	Y
Supervision/team	Y	Y	Y	Y
Self-observation—therapist	Y	Y	Y	Y
Skills in managing suicidality, including balanced response	Y	Y	Y	Y
Self-observation—client	Y	Y	Y	Y
Identifying emotions	Y	Y	Y	Y
Analysis of events leading up to and following events	Y	Y	Y	Y
Additional topics not discussed in chapter text				
Treatment manual	Y	Y	Y	Y
Assessment	Y	Y	Y	Y
Diagnosis shared	Y, 'sensitively'	?	Y, with cautious optimism'	Y

(continued)

SCM - Structured Clinical Management (Bateman + Fonagy, 2009)
GPM - General Psychiatric Management (McMain et al, 2009)
GCC - Good Clinical Care (Chen et al, 2008, 2009)
SP - Supportive Psychotherapy (Clarkin et al, 2007)

Table 2.1 (*Continued*)

	SCM	GPM	GCC	SP
Sessions regularly scheduled	Y	Y	Flexible	Y
Family involvement	Y	?	Y++	?
Support	Y	Y	Y	Y
Positive transference left alone	?	Y	?	Y
Medication as adjunct	Y	Y	Y	Y
Medication goal explicitly includes avoiding undue side effects	Y	Y	Y	?
Acute hospitalization goal: brief goal directed	Y	Y	Y	?
General psychiatric review built in	Y	Y	Y	?
Clear organizational structures	Y	Y	Y	?
Promote treatment planning	Y	Y	Y	?
Treatment plans	Y	Y	Y	?
Crisis contact availability with therapist during usual hours	Y	Y	Y	?
Crisis service availability coordinated after hours	Y	Y	Y	?
Promote crisis planning	Y	Y	Y	?
Present day focus	Y	Y	Y	?
Problem-solving skills	Y	?	Y	Probably not
Client outcome evaluation clinically built in	Y, via supervision	Y, formally	Y, via team meeting	?
Assertive outreach for nonattenders	Y	?	Y, early in treatment	?
Case management	Y	Y	Y	Probably not
Advocacy where indicated named	Y	?	Y	?
Support seeking housing/finance/ vocation where relevant named	Y	?	Y	Probably not

Y, Yes; N/A, not applicable.

contexts, being designed to deliver standardized high-quality treatments considered to be achievable in economically developed countries. This chapter elucidates and clarifies the common features of the treatments and suggests what the active ingredients of change might be.

Appendix 5 - Implementation Plan

1. Services to continue to ensure all staff, as appropriate as set out in these documents, complete New to Forensics, New to Essentials of Psychological Care programme and the new Learnpro module on Working with Personality Disordered Offenders and the existing Relational Security module as appropriate. NES to roll out Working with Personality Disordered Offenders Learnpro module.
2. Local services to review their ward environments and consider whether they fulfil requirements of Structured Clinical Care (see Appendix 4) and make necessary adjustments as deemed necessary.
3. Local services to consider either existing training options or the development of new training packages for in-depth training for working with patients with personality disorder. Forensic School/NES to be approached about whether this can be provided nationally.
4. Inpatient Clinical Teams to consider their admission process and whether they currently incorporate a personality disorder assessment or whether this needs to be introduced. These assessments will clearly have to take into account the presentation of the patient with regard to mental illness and whether this affects the timing of a personality assessment.
5. Inpatient clinical teams to ensure that all ongoing patients have a psychological formulation that incorporates personality functioning. It is currently understood that all high, medium, low secure, and community services have access to a psychologist and/or psychological therapist. Community teams should consider at which point in a patient's pathway they require a psychological formulation to be available.
6. Psychologists and psychological therapists receive supervision as outlined in Professional Guidelines and Accreditation Standards. Reflective Practice is considered good practice and local services should ensure ongoing provision. Ward-based reflective practice should be facilitated by a member of staff who is competent in providing reflective practice and who is preferably not a ward-based member of staff in order to provide the appropriate degree of objectivity. Local services should ensure that reflective practice is available and provided in an appropriate manner.
7. It is currently understood that all high, medium and low secure settings have access to psychology staff and/or psychological therapists who are trained in therapeutic models effective for Personality Disorder. Services need to ensure ongoing provision for psychological input to meet this requirement, i.e. staff who can provide more than one therapeutic approach to personality disorder. Staff providing psychological treatment need to have access to training in relevant therapeutic models as required.
8. Local services to consider whether resources are currently available to provide consultation outwith their own service, i.e. to other NHS Services or Criminal Justice Services, in terms of availability of qualified staff. In addition they should consider how this is provided, e.g. telephone consultation, face-to-face meetings with staff, assessments of clients if required.
9. Clinical Teams to ensure personality dysfunction or disorder is taken into account when developing risk management strategies. The in-depth training outlined below may be helpful if staff feel unable to incorporate this at present.
10. Over and above, the reflective practice mentioned above, services should have the ability to access a psychotherapist competent in personality disorders and preferably in forensic working, where cases would benefit from that input.
11. Services need to review their internal Serious Incident Review processes in light of this and ensure that external teams who may conduct SIRs have an awareness of the complexities of working with patients with personality dysfunction. This should be set out in the Terms of Reference of the Review.
12. Services to ensure their selection process allows potential new recruits to demonstrate their ability to deal with difficult interpersonal situations. It is assumed that within the NHS Values Based Recruitment approach, this standard will already have been addressed.