Principles of Structured Clinical Care

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1. INTRODUCTION

A paper on the Principles of Structured Clinical Care was commissioned by the Forensic Matrix Working Group in 2016 following the publication of 'Psychological Approaches to Personality Disorder' (Russell, 2016). A paper on Reflective Practice Competencies was also commissioned at the same time and should be read alongside this paper. A working group was convened to deliver each project.

For this project, the working group were aware of the disparity in resource across the Forensic Network in Scotland in terms of psychological practitioners but felt it was important to keep the document focused on what would be necessary and appropriate while being aware that this could be construed as 'aspirational'. We are aware that not all services could achieve this right now but it sets out where services may want to get to.

This paper is about the care of patients within forensic secure care and community care who have significant interpersonal or intrapersonal difficulties, sometimes referred to as personality dysfunction or disorder. The working group also acknowledge that personality disorder is a term that has negative associations and connotations for some patients with the diagnosis. However, the group are also clear that the focus of this paper is not limited to those with a diagnosis of personality disorder and is not diagnosis specific. Russell (2016) highlighted the need for all clinical staff to be aware of the personality functioning of their patients, regardless of diagnosis, as it has implications for their treatment and risk management. The paper also laid out the research highlighting significant rates of personality disorder and dysfunctional personality traits within a forensic patient population. In Scotland, the majority of patients in forensic services do not have a primary diagnosis of personality disorder. However, just as there is a drive for all services to be trauma-informed, given the significant rates of personality disorder and dysfunction in patients in forensic services, there is a need for forensic services to be responsive to the personality functioning of their patients. Finding a term that is palatable to all who will read this document has proven difficult. Russell (2016) referred to personality dysfunction; the term 'complex relational problems' has also been used. For this paper we have chosen to use the term 'personality dysfunction' as this follows on from the language used in the Position Paper. It is the hope of the working group that this paper will promote the consideration of 'personality' when considering the needs of patients and in formulation rather than promoting the use of 'personality disorder' as a term.

Alongside the care of patients in forensic settings, Structured Clinical Care (SCC) acknowledges the important issue of staff wellbeing in these often stressful, kinetic work environments. SCC is in part a way of considering how to organise forensic clinical settings from a relational perspective, with the patients at one side of the interpersonal and staff at the other. Both parts of this system must be considered to allow for a healthy, productive milieu to flourish.

In this paper we will set out: a brief overview of the literature we have reviewed in developing the principles; a definition of SCC; the principles of SCC; and conclude with some thoughts about the potential impact of the principles. The paper has a number of appendices which

contain the full literature review, NICE guidelines, the principles, and a proposed checklist by which services could consider whether they are meeting the principles.

This paper will address the role of whole systems and environments in the care, management and treatment of patients in forensic settings. This approach has parallels with other recent developments looking at the role of psychologically informed approaches and environments and trauma-informed care. The Principles of SCC will address how forensic services can be more responsive to the needs of the patients with personality dysfunction within their care. The principles will acknowledge that in creating a responsive environment that has a therapeutic impact for patients, there is a need to consider staff training and support as a therapeutic environment relies on a trained and informed workforce.

2. BRIEF OVERVIEW OF LITERATURE

The literature we have reviewed in preparing this paper falls into three main areas: Research literature, clinical guidelines/professional best practice documents, and National Drivers. Readers of this paper are referred to *Psychological Approaches to Personality Disorder* (Russell, 2016) which provides an overview of the recent developments in this area (see also Appendix 1).

2.1 Research Literature

Russell (2016) highlighted that recent developments in research into psychological treatment for personality disorder have had two forms. One is the Randomised Controlled Trial approach and the other is looking at the whole systems approach to working with patients. The other research has started from looking at the whole system and categorising and describing all the things that need to occur to create an effective milieu, i.e. UCL model. Confusingly, the terms used to describe control group therapies and milieu have been similar (Russell, 2016; see Appendix 1). For the purposes of this paper the responsive environment and systems wide approach is the relevant topic of consideration. Most forensic services in Scotland have access to psychologists or psychological therapists who can deliver individual or group based therapies, albeit that the resource for this varies between services. Whilst the research evidence on therapies has been developing, in recent years there has also been an increasing amount of publication and convergence of opinion on the role of the wider system and team and how this in turn contributes to the development and maintenance of a responsive therapeutic environment for those with personality disorders.

Recently there have been several publications that have arisen through the work being undertaken in the PD Offender Pathway in England and Wales. The focus of therapeutic work with offenders with personality disorder in England and Wales has moved away from work in high secure facilities to work in the community and to a certain extent prison. The pathway has introduced a model whereby psychologists work alongside probation to make sure work done with these offenders is formulation-driven and psychologically-informed. The pathway has promoted the development of Psychologically Informed Planned Environments (PIPEs); these currently exist in units in prison or exist within community hostels for offenders. The original strategy from 2012 described PIPEs as "specifically designed environments where staff members have additional training to develop an increased psychological understanding of day-to-day work with offenders. This understanding enables staff to further develop a safe and facilitating environment that can support offenders to retain the benefits gained from treatment, to test offenders to see whether behavioural changes are retained and to facilitate offenders to progress through the system in a planned and pathway-based approach. These enhanced environments will be prison wings, approved premises in the community or hospital wards" (Joseph & Benefield, 2012, p.216). The research literature provides different descriptions of projects running PIPEs. Components of work introduced in the pathway include staff training in personality disorder, supervision and reflective practice for staff, joint formulations developed between psychologists and staff and introducing a psychological framework to understand clients. The components vary between services depending on

whether they are community based (joint work between probation and psychology) or residential (PIPES). Recent research from the pathway has highlighted a range of positive outcomes that can be demonstrated from employing these approaches (see Appendix 1), i.e. improved knowledge and awareness of personality disorder in staff groups, lower rates of recall to prison for those on probation, reduction in challenging behaviours and non-compliance with supervision, better working relationships between clients and staff.

2.2 National Drivers and Clinical Guidelines

The UCL competency framework lays out the knowledge and skills required for working with patients with personality disorder. Within this they use the term 'generic structured clinical care'. They explain it is not a direct alternative to specific psychological therapies but can be useful for clients who are unwilling or unable to engage in psychological therapies that require a certain degree of structure and intensity to be effective. This work has since been developed by Bateman and colleagues in their development of Structured Clinical Management of Borderline Personality Disorder (Bateman & Krawitz, 2013). This work was of interest to the group as it considered the care of personality disorder as being beyond just individual therapy and both the competencies and the delivery being held within the team and services. It also highlights the need to consider how services respond to patients who, for whatever reason, cannot engage in therapy.

The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder (*Shining lights in dark corners of people's lives*, 2017) was a significant document developed by a range of people interested in personality disorder; from service users to clinicians to politicians. It highlighted the problems there have been in the delivery of treatment historically and made recommendations for how service should develop. It highlights the need for services to be trauma-informed, formulations being at the heart of the pathway rather than diagnosis, and acknowledged the work of the PD offender Pathway as an example of good practice. In particular it outlines the core tenets of an effective intervention being:

- developing a consistent therapeutic environment and network of services
- a consistent and respectful therapeutic relationship in which a real sense of partnership can develop
- psychologically-informed practice
- individual formulations
- and a trained workforce

There are several national drivers currently that provide a context for the development of this work. At a national level, NHS Education Scotland has recently published the *Trauma Knowledge and Skills Framework* which highlights the high rates of trauma within the general populations and population seeking care from the NHS and the need to be response to this. The framework distinguishes between services in terms of the degree to which they need to incorporate trauma into their service planning and delivery. This will depend on the degree to

which the treatment of trauma is a core aspect of their care. This document is clearly of significance to forensic services. Many of the clients in forensic services have a history of trauma. Indeed this is not unrelated to the significant numbers of clients with personality dysfunction. There is a well understood link between having a history of trauma and developing a personality disorder. Patients with a diagnosis of Borderline personality disorder have been consistently found to be more likely to have childhood trauma (Herman, Perry & van der Kolk, 1989; Goodman & Yehuda, 2002; van der Kolk, Hostetler, Herron & Fisler, 1994). This development of personality disorder and personality dysfunction is seen to be mediated through the affect regulation problems that result from early trauma. The Trauma framework was preceded by *Promoting Excellence* which took a similar approach to dementia care within the older adult population, highlighting the prevalence of this disease the need for services to be responsive to the needs of patients with this disease regardless of whether it is the primary reason for contact with services. In a similar way to this paper, these documents highlight the need for an informed and trained staff group and the role and impact of the whole service in its interactions with patients rather than looking at discrete episodes of treatment. There is a similarity of approach between these frameworks and the intent of this paper which is to look at the responsivity of the whole system to the needs of the patient.

Within the field of psychology and, in particular, clinical psychology, there has been an increasing focus on the role of psychologists in taking a contextual approach to patient care. Within this, the role of psychological formulation, and in particular, team formulation, has been increasingly highlighted, e.g. Power Threat Meaning Framework (Johnstone, L. & Boyle, M., 2018), and Psychological Best Practice in inpatients services for older people (Ross & Dexter-Smith, 2017), Clinical Psychology Forum: Special Edition Team Formulation (2016) all published by the British Psychological Society. These documents demonstrate some services adopt an agreed approach to formulation that is used for all patients, e.g., a CBT formulation or an attachment based formulation. The benefits of this approach are that staff get repeated exposure to one type of formulation rather than different styles that different clinicians use. The team formulation also provides consistency and continuity in patient care. The PTM Framework in particular highlights the work in the PD Offender Pathway in England and Wales as being a good example of this work.

The Royal College of Psychiatrists has developed the Enabling Environments initiative (RCPsych, 2013). This is an integrated set of guidelines and standards whereby services can apply to be recognised in this scheme by creating an environment where ‘people can develop, grow and flourish’ (p.7). The role of patients and staff in helping to create these therapeutic environments is at the core of the standards.

2.3 Staff Wellbeing

Staff wellbeing and attitudes have been identified in research as potential key outcomes and components of SCC. As already highlighted by Russell (2016) Moore (2012) has proposed key principles and practices for staff working with clients with personality disorder that are likely to promote resilience, and hence wellbeing, in Personality Disorder services. These can be grouped into the areas of: Staff selection; Training; Support; and Responsive management.

Staff training, as described above in both the SCC and Moore's framework, is important to help with feelings of wellbeing and to improve attitudes. For example, an evaluation of the Level 1 training of the Knowledge and Understanding Framework for Personality Disorder in England and Wales showed that immediately post-training staff showed an improvement in levels of understanding and capability efficacy and a reduction in negative emotional reaction. Although after 3 months, capability efficacy had reduced to pre-training levels, 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). The latter, of course, are key requirements for SCC.

Additionally, work by Bowers et al (2006) has shown that when staff have a more positive attitude to personality disorder was associated with improved general health and job performance, decreased burnout, and a favourable perception of managers. Part of the construction and maintenance of a successful SCC environment would involve training staff in ways that can help improve attitudes to patients including those with personality disorder; who often considered to be the most problematic and difficult for staff to securely contain in both the internal and external world. Possessing a better attitude therefore improves staff wellbeing and patient care.

Within the DoH/NOMS Practitioners Guide on Working with Offenders with Personality Disorder, Staff wellbeing is assigned a whole chapter. This chapter underlines the importance of staff, first and foremost, as key components in the delivery of a functioning service for patients with personality disorder. They highlight the specific challenges that staff who work in these services face due to the interpersonal nature of the patient's problematic presentation. Staff burnout is a key concern which can negatively impact not just staff, but patients and organisations as well. The chapter contains useful information on highlighting the symptoms that staff with burnout may experience. Specifically they highlight the work of Maslach and the 3-factor conceptualisation of staff burnout:

De-personalisation and Cynicism	**Feeling Ineffective**	**Emotional Exhaustion**
Negative and cynical attitudes and feelings about offender which can lead staff to view them as somehow deserving of their troubles	Feeling unhappy and dissatisfied about personal accomplishments at work	Physical fatigue and a sense of feeling psychologically and emotionally 'drained' from excessive job demands and continuous stress.

They also highlight the work of Scott (2006) and the aspects of the job that may increase the likelihood of staff burnout (see Appendix 1). In terms of recommendations they highlight the importance of support, training, supervision, reflective practice, clarity about the job and realistic expectations and a healthy work life balance.

2.4 Conclusion

The review of the literature therefore highlighted that, although there is a lack of substantial clinical trial evidence in the area of a responsive therapeutic environment for those with personality dysfunction, there was a convergence in the literature about a number of key principles that were important, i.e. teaching and training for staff in personality disorder and helpful ways of working, this informed staff group being key to a responsive environment, formulation being key to informing staff interactions with individuals, a consistent framework in which to understand patient's problems, and the importance of reflective practice groups and supervision. These form the basis for the principles in this document.

3. STRUCTURED CLINICAL CARE IN SCOTLAND

3.1 Definition of Structured Clinical Care

An approach to clinical care that is:

- Comprehensive
- Systems wide
- Multi-disciplinary
- Psychologically informed
- And is underpinned by a Reflective and Responsive Environment

The core purpose of Structured Clinical Care is to create a clinical environment where:

- staff will have sufficient training on personality and how to work with a person with personality dysfunction
- staff have a shared understanding of the person (formulation) and follow shared interactional guidelines that are formulation driven
- the patient meets appropriate and consistent responses from the staff in everyday interactions. Appropriate, in this context, means related to the formulation.
- The patient can access individual psychological treatment where appropriate.

Within this environment, the patient is therefore clinically supported throughout the day via everyday interactions and relationships, rather than treatment happening just at discrete times in a week or day. Consistency and continuity of management attitude and approach is vital. This places an emphasis on all staff working with a patient to understand the patient's strengths and needs. The psychological formulation is a vehicle that allows this to happen. A consistent staff group that is working together in a way that reflects the needs of the patient is supportive of both patients and staff, and creates an environment that allows a patient to feel contained and able to engage in making positive changes. In order for this clinical environment to work and be sustainable, certain elements are required, i.e., training, formulation meetings, multi-disciplinary Reflective Practice Groups. The psychological framework and individualised formulations drive interactional guidelines which is how consistency and continuity is achieved. Where staff follow interactional guidelines developed for a patient, the patient experiences consistent interactions across staff shifts but also staff changes. It can also ensure that when patients move from one service to another, good ways of working, along with the rationale that explains how they were arrived at, are not lost. In a similar way to staff, who can find moving jobs around settings and Health Boards unsettling and can take time to adjust; patients who have built relationships with staff and patients and adapted to the milieu and approach in one setting can experience moving to a new setting and making new relationships as stressful, particularly those who have attachment difficulties or problems building relationships already (Ainsworth & Bowlby, 1991; Bowlby, 1969, 1973, 1980a). Providing continuity in how staff relate and understand individual patients would be expected to provide some protection against this distress and disruption. The environment also supports staff through training, support, supervision and reflective practice to maintain expertise but also resilience at work.

3.2 A service model

Our proposed model is intended to be an efficient, evidence-based, and effective model of service provision where there is a cost effective use of resources, which in this case is staff time and expertise. The systematic approach is represented in Figures 1 and 2.

Figure 1

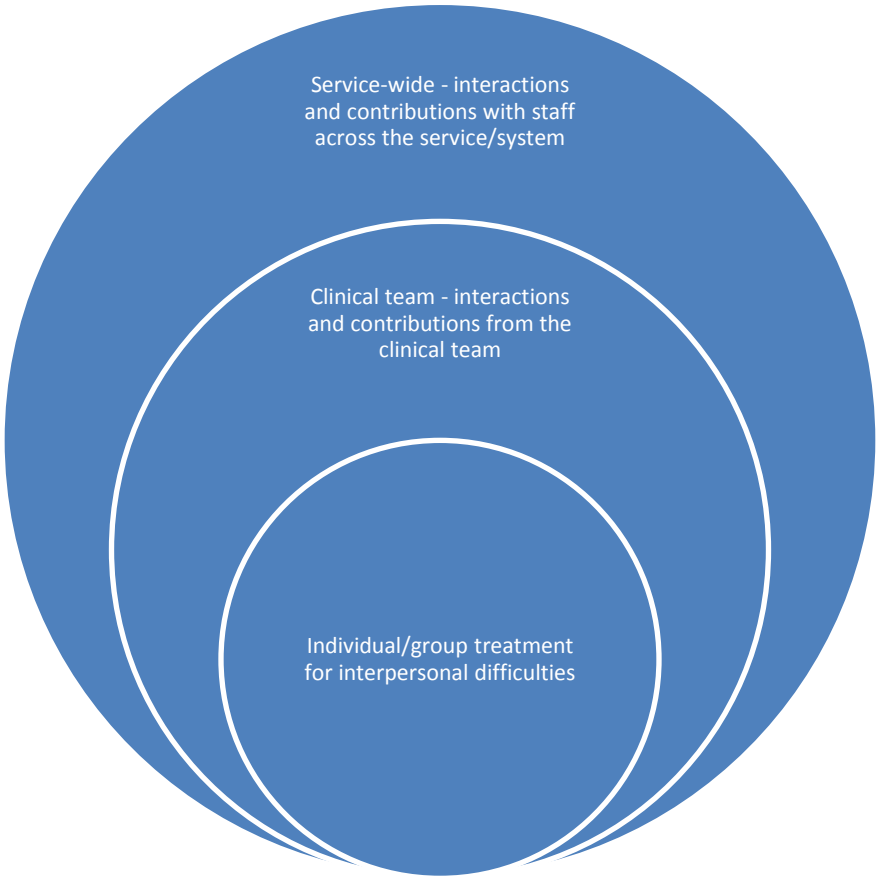
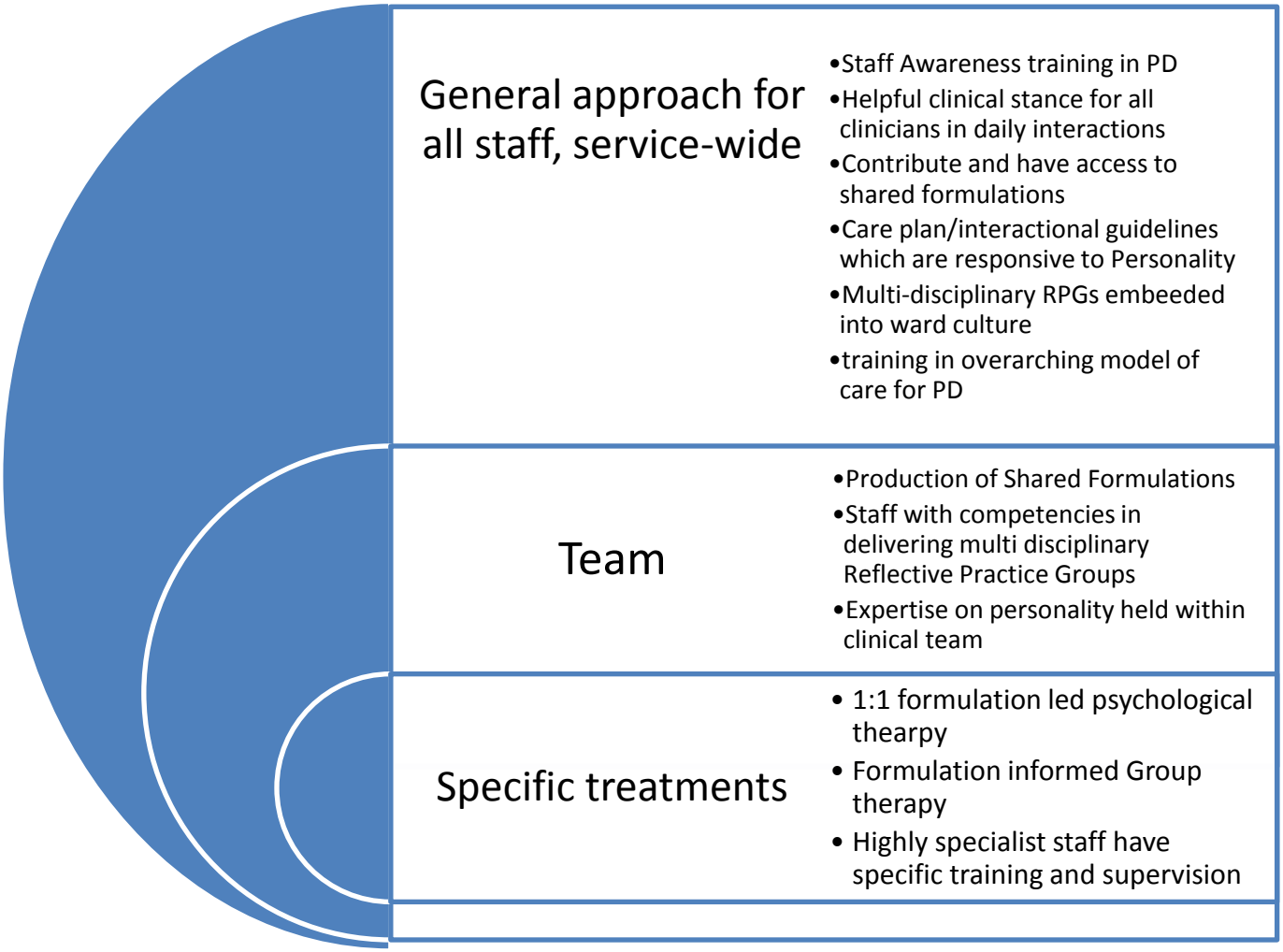


Figure 2



The model therefore has three different parts (Figure 1). The first and largest part (outermost circle in figure 1) signifies that all staff in the service have a role to play in the treatment and management of patients. This includes a helpful general stance for all clinicians to take in daily interactions with patients, the system ensuring that staff have the requisite training and support, engagement in multi-disciplinary Reflective Practice Groups to support clinicians and to help sustain these therapeutic interactions with patients. The second part is the work that is being provided and coordinated at the multidisciplinary team level via formulation, interactional guidelines, risk assessment for particular patients. This feeds into the first part of the system - i.e. guides individual interactions – and also guides the individualised specific treatment of difficulties associated with personality disorder which is represented as the third part of the model (smallest circle). Although the diagrams show three discrete parts, in reality

there is fluidity between levels as they are interrelated e.g., the psychological formulation is produced at the team level but this can only be done with contributions from staff across the service and needs to be available to staff across the service. Training delivered at to all staff service-wide will allow people to understand why formulations are undertaken and the role that they play in developing management strategies.

The distinction between parts is important when thinking about the implementation of SCC: what training is required, who requires the training and what should be the expected outcomes of delivering training. For example, staff who are providing clinical input at the specific treatment level will have different needs to those working primarily at the service-wide and team levels. Staff working primarily at the service-wide level are likely to benefit from awareness training in formulation in order that they can understand how to contribute to a formulation and how they can use it to support work with patients. Furthermore, staff working mainly at the service-wide level who much of their time in continuous contact with patients may have particular needs related to the challenges of this kind of work i.e. particular training and support to sustain therapeutic daily interactions with disturbed and disturbing patients. Such training and development is also designed to improve the general health and wellbeing of staff at work. The psychology resource supports the development of formulations and the consideration of the implications for interactional guidelines but requires the whole service to implement.

Within the SCC model, the expectation is that the middle part is operating in relation to the outer part, i.e. the clinical team have training and awareness of personality – not just in understanding current diagnostic criterion of Personality Disorder but in understanding personality traits and dysfunction. It is also important that they are clear about the relevance of personality to treatment, risk and management and thus understand the critical role that staff interactions and responses can play. The aim and expectation is that staff incorporate the discussion of personality into discussions about patient care. This could be based on their interactions, but also the use of screening measures, e.g. SAPAS, OASyS PD Screen, or full personality or personality disorder assessments (Shaw, Minoudis & Craissati, 2012). This is then used to develop care plans around how the patient is managed on the ward in terms of interpersonal interactions and planning activities – triggers and Early Warning Signs for offending may be identified.

4. PRINCIPLES OF SERVICE PROVISION

(Outlined in Appendix 3)

1. All staff are given knowledge and awareness training in Personality Disorder

2. Services should recognise within recruitment procedures that staff in forensic settings will be working with patients with personality dysfunction and that staff who are recruited are motivated to do this work

3. All services have a psychological framework underpinning clinical interactions, i.e. guiding how we interact with patients and each other.

4. The therapeutic environment has a focus on engagement, managing relationships, collaboration, and clear boundaries.

5. a) All patients have a case formulation that outlines early experiences, the development of personality functioning, and offending behaviours and personality strengths and is kept under regular review.
   b) All patients have opportunity to collaborate with their case formulation
   c) Staff in the care team can contribute to the case formulation
   d) Staff in the care team have access to case formulation and it is available for care planning meetings and risk meetings
   e) Care plans include guidelines on how to interact with the patient on the basis of the formulation

6. Multidisciplinary Reflective Practice Groups are embedded into service culture and ward structure.

7. Clinical supervision is provided for all clinicians and embedded into the service

8. All services have staff who are trained in psychological therapies that have an evidence base for personality disorder. These therapies should be delivered within a coherent clinical governance structure

5. SERVICE WIDE LEVEL

5.1 Staff Recruitment and Training

Principle 1: All staff are given knowledge and awareness training in Personality Disorder

Responsivity is one of the key principles behind the treatment of offending behaviour. The more responsive we are to patient's strengths and weaknesses, the more likely our treatment is to have a positive outcome. Importantly, personality traits can be both strengths and weaknesses. Often our focus on personality in forensic settings can lead us to focus on personality dysfunction. However our patients often have positive personality traits that we can engage with to encourage progression and success in both improving mental wellbeing and reducing risk of reoffending. When assessing personality looking for evidence of both strengths and weaknesses will give us a more holistic understanding of a person and may also increase the chances of engagement.

This means that there is a need to have a staff group from all disciplines, that is informed about personality functioning. Staff need to have knowledge and awareness of what relevant personality traits and personality disorder diagnoses are, how to identify signs and symptoms of personality dysfunction, how best to work with patients with problematic personality traits, including how to look after staff wellbeing as well as patient wellbeing. Within staff groups there needs to be the ability to screen and assess for personality traits.

Although it is assumed that all professional disciplines will have had training on personality disorder in their professional training, it is recognised that awareness training on commencing work in a forensic service will be necessary in order to highlight the specific issues that are pertinent to forensic services, i.e. the relationship with risk, the potential for boundary violations, the impact on staff wellbeing. It also needs to be acknowledged that there are staff in forensic services that are 'un-trained', i.e. nursing assistants, administrative staff and domestic staff, who are also likely to benefit from education on personality. Some of this work is currently provided within the New to Forensic Programme. However each service will need to consider what training they need to deliver to the staff as a whole and to particular staff groups. Each service also needs to consider on the basis of the nature and configuration of their service what training is required. All of this means that it is important that senior managers have training in personality disorder and dysfunction and the management of it so they can understand the needs of their staff.

Principle 2: There is recognition within recruitment procedures that staff in forensic settings will be working with personality issues and that staff who are recruited are motivated to do this work.

This starts with recruitment processes that take into account the need for staff to have the capacity and ability to work with patients with personality disorder. In the first instance this

means potential new recruits need to understand that the client group they will be working with is known to have significant personality issues and have the motivation, and resilience, to work with this type of presentation. They also need to demonstrate an ability and willingness to reflect on their own responses to the clinical work and patients, including an awareness of multi-disciplinary Reflective Practice Groups (RPGs) and why they are important.

5.2 Therapeutic milieu

Principle 3: all services have a psychological framework to formulate personality functioning

Where services have an overarching clinical model/therapeutic milieu, new recruits should receive introductory and awareness training in the model. This training would attend to: what the model or milieu is, its overarching principles, and the role of staff within the model. This is important because this will affect how staff interact with patients, support or challenge patients, model behaviour to patients, and support each in other in their work with patients. It will also obviously make clear why certain systems are in place.

From a patient point of view, on admission to forensic services, a screening or assessment of personality may take place. This will depend on how stable the patient is, with respect to mental illness, and the length of their Order or admission. Incorporating this knowledge into a care plan will be important in terms of how staff interact with a patient and plan for any difficulties that may arise.

Whichever model is considered by services to help implement SCC, it is important that it can be translated, in a way that means all staff groups can engage, e.g. minimal use of jargon. This will help with acceptance from all grades and levels of clinical, managerial and professional disciplines in Forensic Mental Health Services. Additionally, having an SCC model that is not held exclusively by one discipline will make it easier for all disciplines to get involved. If staff find it difficult to engage with the model, for example due to the use of too much jargon or because the basic underlying concepts of the model are not communicated clearly, this will limit the potential for maximising positive outcomes. Services adopting SCC will require not just a psychological model to underpin it but also a framework of ethics, value and approach for the SCC environment to function.

Additionally, although psychological formulation underpins this work, SCC must be seen to be beyond the sole province of psychological practitioners with nursing care, medication and other forms of therapy playing a valuable role, as and when it is required.

Principle 4. The therapeutic environment has a focus on engagement, managing relationships, collaboration, and clear boundaries

The therapeutic environment relies heavily on the way in which staff interact with patients. All staff should strive to demonstrate the principles of compassion, curiosity and empathy when working with people with personality dysfunction and challenge stigma by promoting good attitudes to working with people with personality dysfunction (see principle 6 for explanation of how it can be difficult to sustain an empathic and curious approach when working with patients, and the role of multi-disciplinary Reflective Practice Groups in helping in this area). The stance of the clinician in relation to the patient is important. There is a need to build and maintain engagement. This will involve being able to look at de-escalation, conflict resolution, managing 'ruptures' in relationships when they arise. Engagement can also be enhanced by validating a patient's experience and demonstrating empathy, whilst providing support to make positive changes. Clear boundaries allow patients and staff to understand their roles in relation to each other. Building a collaborative relationship enables patients' voices to be heard, taken into account, and be involved in their care planning. Transparency along with collaboration allows for trust to be built which provides a solid foundation on which to plan care.

Staff should aim for a consistent approach to patients, including across different shifts. Furthermore, continuity of clinicians, especially key staff, is aimed for, and when staff leave and enter services and they are aware of the potential meaning for patients of these changes and attend to them appropriately. All these dimensions will also allow staff to feel contained and held by their working environment, improve relationships with patients as well as with each other hence hopefully leading to an increased sense of satisfaction and wellbeing.

6. TEAM LEVEL

Clinical teams should be multi-disciplinary in nature to ensure breadth and depth of service provision to the patients that they will be working with in terms of nursing care, psychologically informed treatments and assessments, direct psychological therapies provision, medical, occupational therapy and social work input. It will be important for the team to have a responsible medical officer (RMO) as part of it, to ensure that patients can be managed under formal mental health act provisions if they are required.

6.1 Formulation

Principle 5a: All patients have a case formulation that outlines early experiences, the development of personality functioning (emotions, cognitions, behaviour) and current personality functioning, and offending behaviours and personality strengths.

A formulation is an attempt to describe and explain a person's problems in terms of the range of factors which contribute to the development and maintenance of the problems. It aims to capture what is individual and unique about the person. Its purpose is to guide interventions and risk management strategies and it achieves this by generating hypotheses to explain why certain behaviours have developed. There are a range of psychological theories that can be used to structure a psychological formulation, for example, learning theory, information processing theory, psychoanalytic theory and attachment theory. Each of these theories provides a framework for organising and linking the information that have been collected about a person during the assessment process.

For SCC purposes, the formulation needs to explicitly reference personality functioning. It should explain, where appropriate, the difficulties in personality functioning experienced by the person, as well as other difficulties including offending behaviour. Along with understanding the development of this behaviour, and providing a pathway for formal psychological interventions, the psychological formulation should inform all aspects of care planning by all disciplines. This can be done at a variety of layers and intensity. For example, where a formulation indicates that a person's interpersonal violence can be triggered by feelings of humiliation, care plans can indicate that when they require to be given feedback on their behaviour, that this should be done away from peers and care should be taken to ensure that the stance of the staff member doing this is calm and non-punitive. As such, the formulation can be seen as the central component of all care and treatment provided to the patient and not just formal interventions. Services therefore need to prioritise the development of a formulation and develop governance systems to ensure good quality, responsive formulations that can support all disciplines interactions with the patient.

Discussions around personality functioning and its role in risk management can inform decisions about whether there is a need for a full personality disorder assessment including consideration of psychopathy.

Principle 5b: All patients have opportunity to collaborate with case formulation

Where patients are able and motivated, they should be involved in the development of the formulation. It is recognised that there are times when a patient may not be able to contribute, e.g. they are acutely unwell, and this should not preclude teams from undertaking formulation work. However, the process of involving the patient in the production of a shared formulation may have several benefits, e.g., increase engagement with the team, open up a dialogue about potential treatment options, elicit new information from the patient.

Principle 5c: Staff in the care team can contribute to and have access to case formulation and it is available for care planning meetings and risk meeting

Principle 5d: All formulations are regularly reviewed to incorporate new information

Formulations should be regularly reviewed to make sure they take into account new information, new experiences of interacting with the patient, and reflect any change, both positive or negative, that has been observed. This should involve the whole clinical team and staff group around the patient.

Principle 5e: Care plans include guidelines on how to interact with the patient on the basis of the formulation.

As the formulation should not exist in a vacuum it is important care plans include recommendations and guidelines on the best ways to interact with a patient based on the formulation. Using formulation in these practical ways, hopefully highlights that it is more than a theoretical exercise and that it has meaning for how we manage patients.

6.2 Reflective Practice and Supervision

Principle 6: Multidisciplinary Reflective Practice Groups are embedded into service culture and ward structure.

Attention should be paid to the wellbeing and resilience of staff members who work with individuals with personality dysfunction. A core part of personality disorder is an entrenched pattern of maladaptive behaviour which can be damaging to self or others. Within our context this could include a patient who appears to want help but is hostile when it is offered, or who places high demands on staff time with a sense of entitlement. It is expected that staff will have an emotional reaction to these behaviours and may experience a range of emotions and

reactions such as frustration, anger, feeling manipulated. Over time this can have a cumulative impact on staff and these emotional responses can be amplified. If staff do not have the opportunity to make sense of these challenges, these emotional responses can impact on behaviour and staff can begin to feel critical towards patients and lose capacity for empathy. Along with the demands of managing the risk of violence and having to work within strict protocols and procedures of forensic institutions, staff are at increased risk of experiencing burnout. Multi-disciplinary Reflective Practice Groups (RPGs) can support staff in this environment to ward against the risk of burnout.

Multi-disciplinary Reflective practice Groups (RPGs) are a reflective space for staff teams to reflect on their clinical work with complex patients and understand some of the dynamics that they are part of, e.g., staff, team, and organisational. Led by an appropriately trained facilitator (ref competency paper), they provide containment for teams and help staff to make sense of their emotional responses to the work, which links with staff resilience. Multi-disciplinary RPGs support staff to remain open to working with their patient and understand their emotional responses. This can then build team cohesion through a greater understanding of how patients are impacting the functioning of staff within the team. Staff are better able to attend to the tasks of work. This in turn reduces burnout and contributes to a positive therapeutic milieu and reduced levels of sickness. These groups are recognised as highly recommended for the safe and sustainable running of units that work constantly with disturbed and disturbing patients. Services need to not only provide regular RPGs, but work to have it seen as integral and necessary to practice (see Forensic Network Reflective Practice Competencies paper).

Principle 7: Clinical supervision is provided for all clinicians and embedded into the service

Clinical supervision is a discipline specific space where staff can review and reflect on their practice, discuss individual cases in depth, and identify any changes in practice needed and training requirements. It complements multi-disciplinary Reflective Practice Groups (not replaces it) and also needs to be offered and considered as an integral part of practice.

7. INDIVIDUAL LEVEL

Principle 8: All services have staff who are trained in psychological therapies that have an evidence base for personality disorder. These therapies should be delivered within a coherent clinical governance structure

With regards to treatment, many of the issues about treatment are covered in the Russell (2016) paper. There is still limited research into psychological treatment for personality disorder in forensic settings. However the evidence from research into psychological treatment for personality disorder in general indicates that there is some evidence that some therapies work for some people. It would therefore be appropriate that in circumstances where a patient has identified needs in relation to personality disorder, e.g., difficulties in interpersonal relatedness, and they are willing and able to engage in psychological therapy, that a therapy that has demonstrated some efficacy is provided, e.g., CBT, CAT, MBT, Psychodynamic, Schema focussed. As with all patients, responsivity issues need to be taken into account. Some patients may respond well to a CBT approach whilst others may not. Therefore services will have to consider what range of therapies they can provide; do they have appropriate staff who can provide psychological therapy and do the staff available have the relevant training and qualifications to be able to provide more than one therapy, and supervision arrangements in place, i.e. clinical governance.

It is important to note that whereas in implementing SCC, a service may use one psychological model to underpin their approach in order to give a unified approach for staff and patients, when it comes to the delivery of psychological therapy for personality disorder of dysfunction, there is an increasing evidence base for a variety of approaches in the treatment of PD (Lana & Fernandez Saint-Martin, 2013; Stoffers et al., 2012; Consensus Statement, 2018), which should be available to increase patient choice, freedom and autonomy with respect to treatment.

Within SCC, this type of individual psychological therapy should be happening within the whole systems model described. Therefore the treatment does not happen in a vacuum. It is occurring in an environment where all staff interactions are informed by an awareness of personality disorder; there is a milieu or overarching model which in turn informs a formulation of the patient and where staff are supported through RP and Supervision to work therapeutically and responsively with patients. The patient is therefore supported between treatment sessions to achieve goals or make changes as appropriate to therapy. It should therefore also be clear that this individual therapy is not 'the treatment' for an identified personality disorder or personality dysfunction; instead it is one component of a service model that is designed for the purposes of providing a therapeutic environment to address these issues.

8 COMMUNITY AND INPATIENT SERVICES

In writing this document, the working group were mindful of the fact that whereas historically many of the forensic services in Scotland have been in-patient based there are increasingly forensic community mental health teams managing a range of forensic clients in the community. The way in which these services adopt or evidence the different principles may therefore vary based on the nature of the service. The PD Offender Pathway acknowledged the differences between the two in their model. However they highlight the role of staff training and support, and formulation are key to both. The 24/7 nature of inpatient care can often make the potentially difficult interpersonal dynamics between staff and patients, as well as between staff and staff, and patients and patients, more obvious and acute. Splits in teams need to be addressed. Having staff who are already trained, who are supported through supervision and multi-disciplinary Reflective Practice Groups, have a psychological framework for understanding personality dysfunction and a team formulation for a patient are all components that will drive care forward in a positive way. Challenges for an inpatient team may be that the 24/7 nature of the environment means it is hard to find times for teams to meet due to the logistics of keeping wards adequately staffed. In the community, staff teams may spend a lot of time off-site and may find it difficult to find a time to meet. Staff may be more likely to be working in isolation with patients; team formulations will not only allow staff to share ideas and benefit from the resource of the wider team, but the formulation also allows for consistency of approach if that staff member is absent or on leave and other staff members have to cover.

Crisis planning has been recognised in the management of personality disorder. Managing crises in inpatient and outpatient services can be quite different. In non-forensic services, crisis planning often refers to acute risk of harm to self. In forensic services crises care may be managing harm to others. The formulation should guide staff in both predicting when crises may arise and also how best to manage crises.

9. CONCLUSION

The intention of this document is to set out a list of principles by which different services could benchmark, develop, or compare their services in order to ensure they are providing Structured Clinical Care for their patients. In writing the document the working group are aware that for some services, aspects of this may be aspirational due to limited resources, particularly psychological resources. However we would hope that the document will also be helpful for teams to think about the needs of their patients from what might be a slightly different viewpoint when thinking about the impact of personality dysfunction. This whole systems approach identifies that all staff have a role in the care of patients; from HR and managers who are thinking about recruitment and the training that staff require, and the milieu they are promoting, to the front line staff interacting with patients on a day to day basis. Setting out to demonstrate that all principles have been achieved simultaneously may be overwhelming and it may be that a plan identifies principles that need to be prioritised and these may vary across services depending on current practice. The Forensic Network already provide some training opportunities relative to some of the principles described, e.g. Essentials of Psychological Care, Introduction to Formulation.

Overall the group hope that this document contributes to many of the aims that services already have, e.g. to provide more individualised and tailored care for our patients, to be responsive to patients need and to be more trauma-informed.

10. REFERENCES

Ainsworth, M. D. S., & Bowlby, J. (1991), An ethological approach to personality development. *American Psychologist, 46,* 331-341.

Araci, D., & Clarke, I. (2016). Investigating the efficacy of a whole team, psychologically informed, acute mental health service approach. *Journal of Mental Health.* doi:10.3109/09638237.2016.1139065

Bateman, A., Campbell, C, Luyten, P., & Fonagy, P. (2017). A mentalization-based approach to common factors in the treatment of borderline personality disorder. *Current Opinion in Psychology. 21. 10.1016/*j.*copsyc.2017.09.005.*

Bateman, A., & Fonagy, P. (2000). Effectiveness of psychotherapeutic treatment of personality disorder. *British Journal of Psychiatry, 177*(2), 138-143. doi:10.1192/bjp.177.2.138

Bateman, A.W., & Krawitz, R. (2013). *Borderline Personality Disorder: An Evidence-based Guide for Generalist Mental Health Professionals*. Oxford: Oxford University Press.

Berry, K., Barrowclough, C., & Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy, 37,* 39–48.

Bowers, L. Carr-Walker, P., Allan, T., Callaghan, P., & HenkNijman, J (2006). *Attitude to personality disorder among prison officers working in a dangerous and severe personality disorder unit*. *International Journal of Law and Psychiatry (29) 5 p333-342. Elsevier*

Bowlby, J. (1969), *Attachment and loss, Vol. 1: Attachment.* New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss, Vol. 2: Separation.* New York: Basic Books.

Bowlby, J. (I980a). *Attachment and loss, Vol. 3: Loss, sadness and depression*. New York: Basic Books.

British Psychological Society Division of Clinical Psychology (2017). *Psychological best practice in inpatient services for older people (K. Ross & S. Dexter-Smith [Eds.]).* Leicester: British Psychological Society. Retrieved from: http://www.psige.org/public/files/Psychological%20best%20practice%20in%20inpatient%20services%20for%20older%20people.pdf

British Psychological Society Division of Clinical Psychology (2015). *Clinical Psychology Forum: Special Edition: Team Formulation.* Leicester: British Psychological Society. Retrieved from: https://www1.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/cat-1781_-_team_formulation.pdf

Bruce, M., Horgan, H., Kerr, R., Cullen, A., & Russell, S. (2017). Psychologically informed practice (PIP) for staff working with offenders with personality disorder: A pragmatic exploratory trial in approved premises. *Criminal Behaviour and Mental Health, 27, 290-302*. doi:10.1002.cbm.1994

Carradice, A. (2013). 'Five Session CAT' Consultancy: Using CAT to Guide Care Planning with People Diagnosed within Community Mental Health Teams: Brief Summary Report. *Reformulation*, *Winter, p.15-19.*

Chanen, A.M., Jackson, H.J., McCutcheon, L.K., Jovev, M., Dudgeon, P., Yuen, H.P., & McGorry, P.D. (2008). Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: randomised controlled trial. *British Journal of Psychiatry, 193,* 477–484.

Clark, S., & John Chuan, S. (2016). Evaluation of the impact personality disorder project – A psychologically-informed consultation, training and mental health collaboration approach to probation offender management. *Criminal Behaviour and Mental Health*, *26*(3), 186 – 195.

Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F. (2007). Evaluating three treatments for Borderline Personality Disorder: A multiwave study. *American Journal of Psychiatry, 164,* 922-928.

Cole, S., Wood, K., & Spendelow, J. (2015). Team formulation: A critical evaluation of current literature and future research directions. *Clinical Psychology Forum, 275,* 13–19.

Fonagy, P., Twemlow, S.W., Vernberg, E.M., Nelson, J.M., Dill, E.J., Little, T.D., & Sargent, J.A. (2009). A Cluster Randomised Controlled Trial of child-focused psychiatric consultation and a school systems-focused intervention to reduce aggression. *The Journal of Child Psychology and Psychiatry, 50(5), 607-616*

Goodman, M., & Yehuda, R. (2002). The Relationship between Psychological Trauma and Borderline Personality Disorder. *Psychiatric Annals, 32, 337-345*

Herman, J., Perry, C.. & van der Kolk, Bessel, A. (1989). Childhood Trauma in Borderline Personality Disorder. *American Journal of Psychiatry, 146(4)*

Hollingworth, P.. & Johnstone, L. (2014). Team formulation: What are the staff views? *Clinical Psychology Forum, 257,* 28–34.

Johnson, J., Hall, L.H., Berzins, K., Baker, J., Melling, K.. & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications and recommendations for future interventions. *International Journal of Mental Health Nursing, 27, 20-32*

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

Joseph, N., & Benefield, N. (2012). A joint offender personality disorder strategy: an outline summary. *Criminal Behaviour and Mental Health, 22, 210-217*

Kennedy, F., Smalley, M., & Harris, T. (2003). Clinical psychology for inpatient settings: Principles for development and practice. *Clinical Psychology Forum, 30,* 21–24.

Knauer, V., Walker, J., & Roberts, A. (2017) Offender personality disorder pathway: the impact of case consultation and formulation with probation staff. *The Journal of Forensic Psychiatry & Psychology, 28:6*, 825-840, DOI: 10.1080/14789949.2017.1331370

Lana, F., & Fernandez-San Martin, M.I. (2013). To what extent are specific therapies for borderline personality disorders efficacious? A systematic review of published randomised controlled trials (PDF). *Actas Espanolas de Psychiatrica, 41,* 242-252.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., & Lindenboim, N. (2006). Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder. *Archives of General Psychiatry, 63,* 757-766.

Livesley, J. (2005). Principles and Strategies for treating Personality Disorder. *Canadian Journal of Psychiatry, 50,* 442-450.

McMain, S.F., Links, P.S., Gnam, W.H., Guimond, T., Cardish, R.J., Korman, L., & Streiner, D.L. (2009). A randomized trial of dialectical behaviour therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166*, 1365-1374.

Moore, P. (2007). Formulation diagrams: Is there more than meets the eye? *Clinical Psychology Forum*, *174,* 9–12.

Murphy, S.A., Osborne, H., & Smith, I. (2013). Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change. *Aging and Mental Health, 17*(4), 441–448.

National Collaboration Centre for Mental Health (2010). Antisocial personality disorder: treatment, diagnosis and prevention. London: Royal College of Psychiatrists & The British Psychological Society (commissioned by National Institute for Health and Clinical Excellence). Retrieved from: https://www.nice.org.uk/guidance/cg77/evidence/full-guideline-242104429

National Institute for Health and Care Excellence (2009b). *Borderline Personality: Treatment and Management [CG78].* London: National Institute for Health and Care Excellence.

National Offender Management Service & Department of Health (2015). *Working with offenders with personality disorder: A practitioners Guide.* Retrieved March 2018 from *http://www.justice.gov.uk/downloads/offenders/mentally-disorderedoffenders/working-with-personality-disordered-offenders.pdf*

Newman-Taylor, K., & Sambrook, S. (2012). CBT for culture change: Formulating teams to improve patient care. *Behavioural and Cognitive Psychotherapy, 40,* 496–503.

NHS Education Scotland (2011). *Ten Essential Shared Capabilities (10 ESCs) Learning Resource (Scotland).* Edinburgh: NES. Retrieved from: http://www.nes.scot.nhs.uk/media/351385/10_essential_shared_capabilities_2011.pdf

NHS Education Scotland (2017) *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce.* Edinburgh: NES. Retrieved from: http://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf

Nicholson, J. M., & Carradice, A. (2002). Clinical Psychology Provision for Inpatient Settings: A Challenge for Team Working? *Clinical Psychology 18 25-30*.

Ross, K., & Dexter-Smith, S. (Eds) (2017). *Psychological best practice in inpatient services for older people.* Division of Clinical Psychology. Leicester: British Psychological Society.

Roth, A.D., & Pilling, S. (2008). *A competence framework for psychological interventions with people with personality disorder.* London: Research Department of Clinical, Educational and Health Psychology, UCL. Retrieved from http://www.ucl.ac.uk/clinicalpsychology/CORE/Docs/Personality%20disorder%20background%20document%20web%20version.pdf

Royal College of Psychiatrists (2013). *Centre for Quality Improvement: Enabling Environments Standards.* London: Royal College of Psychiatrists. Retrieved from: https://www.rcpsych.ac.uk/pdf/ee%20standards%20-%202013.pdf

Russell, K. (2016). *Psychological Approaches to Personality Disorder in Forensic Mental Health Settings.* Carstairs: Forensic Network. Retrieved from: http://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Position-Paper-Psychological-Approaches-to-Personality-Disorder-in-Forensic-Mental-Health-Settings.pdf

Schön, D.A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass.

Scott, E. (2006). *Job Factors That Contribute to Employee Burnout: What makes some jobs more stressful?* VeryWellMind. Retrieved on 10 October 2018 from (article updated March 2018): https://www.verywellmind.com/job-factors-that-contribute-to-employee-burnout-3144512

Scottish Government (2011). *The Promoting Excellence framework.* Edinburgh: Scottish Government. Retrieved from: http://www.scotland.gov.uk/Publications/2011/05/31085332/0

Shaw, J., Minoudis, P., & Craissati, J. (2012). A comparison of the standardised assessment of personality – abbreviated scale and the offender assessment system personality disorder screen in a probation community sample. *The Journal of Forensic Psychiatry & Psychology, 23:2, 156-167*. DOI: 10.1080/14789949.2012.655763

Shaw, J., Higgins, C., & Quartey, C. (2017). The impact of collaborative case formulation with high risk offenders with personality disorder. *The Journal of Forensic Psychiatry & Psychology, 28:6*, 777-789. DOI: 10.1080/14789949.2017.1324579

Shining lights in dark corners of people's lives (2017) The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder. Retrieved from: https://www.mind.org.uk/media/21163353/consensus-statement-final.pdf

Stoffers, J.M., Völlm, B.A., Rücker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews, CD005652 (8), pp. 1-186.*

Unadkat, S.N., Irving Quinn, G., Jones, F., et al. (2015). Staff experiences of formulating within a team setting. *Clinical Psychology Forum, 275,* 85–88.

Van der Kolk, Bessel, A., Hostetler, A., Herron, N., & Fisler, R.E. (1994). Trauma and the Development of Borderline Personality Disorder. *Psychiatric Clinics of North America, 17(4), 715-730*

11. APPENDICES

Appendix 1 – Review of Relevant Literature

Research Literature

As mentioned above, SCC is a term that has been associated with different concepts. As the control group within randomised control trials (RCTs) for psychological therapy of personality disorder, various terms have been used including Standardised Good Clinical Care (Chanen et al 2008), Structured Clinical Management (Bateman & Fonagy, 2009), General Psychiatric Management (McMain et al, 2009) and Supportive Treatment (Clarkin et al, 2007). The Working group has reviewed all of these. Although they are not identical treatments, in general they describe highly structured, either protocol driven or modularised, treatments delivered by experienced therapists receiving regular supervision. The analysis of the content of the control group treatments in the RCTs highlighted that the authors/developers had developed a control group treatment to reflect evidence-based best practice treatment for personality disorder, as would be expected for a control group in an RCT for psychological treatment of personality disorder. The working group concluded that, in general, while this was interesting in terms of demonstrating that structured, good quality therapies driven by evidence and delivered by experienced supported therapists could produce good or equally good outcomes as recognised evidence based therapies, these were not the focus of this paper. The majority of services in Scotland have access to clinical psychology and qualified psychological therapists who are trained in recognised therapies for personality dysfunction. There would seem little benefit in providing alternatives to that.

Nevertheless, on closer scrutiny, some of these treatments that are described in more depth than others, e.g., Standardised Good Clinical Care (GCC) (Chanen 2008) and Structured Clinical Management (SCM) (Bateman & Fonagy, 2009), clearly involve aspects in addition to individual therapy. Structured Clinical Management discussed the need for a complete assessment, a crisis plan, identifying motivation for treatment, understanding patient and clinical responsibilities, a working formulation of problems for the whole treatment team to appreciate the states of minds of patients and others. Indeed more recently Bateman has published a whole book on SCM. GCC described a modular treatment package developed specifically for the study, described as akin to Linehan's 'treatment by experts' (Linehan et al., 2006) which it used a problem-solving model for all the patients and had optional modules for specific presenting problems, using cognitive behavioural techniques. The therapists involved in the control group received weekly external supervision from a Clinical Psychologist and there was a therapist consultation meeting. The study highlights that GCC was designed to “deliver standardised, high-quality, team-based clinical care that might be achievable in mental health services in more economically developed countries” (Chanen et al, 2008, p.479). The paper highlights patients in both CAT and GCC group had access to crisis care, assertive case management, psychiatric care, activity groups, and in-patient care and pharmacotherapy as needed. These treatments therefore actually start to talk about a whole systems approach to managing a patient rather than just what occurs within a therapy appointment

The concept of psychologically informed management when working with offenders with personality disorder is also clearly outlined within the NOMS/DoH Working with Personality Disordered Offenders document. Although this was primarily designed for probation staff working in the PD Offender Pathway in England and Wales, the importance placed on psychologically informed management in this different setting highlights the direction of travel in terms of how services should work with patients/offenders with personality problems. Within the PD Offender Pathway, psychologists work alongside probation officers to help them work in a more responsive way with offenders who have been assessed as having personality disorder. The published guide is a supportive tool that provides non-clinicians with an overview of personality disorder, explains why it can be difficult to work with this client group and provides guidance on how best to work with different types of personality disorder presentations. There is a clear rationale for this work in that staff who are better informed about their client group are more likely to have more successful outcomes, the risk management plan is tailored to the individual, and staff are more likely to feel they understand the case which will lead to less stress and potential burnout. Probation staff are likely to be meeting with offenders one or two times a week. Building on this concept within inpatient forensic services clearly has potential for greater benefits as staff are interacting with patients almost continuously.

Now that the OPD pathway has been in place for several years, evidence is now being published about some of the outcomes attached to the approach.

Shaw, Higgins & Quartey (2017) published an evaluation of the impact of collaborative case formulation with high risk offenders with personality disorder. Seventy seven Offender Managers (OMs) (probation officers) were randomly allocated to the collaborative formulation (CF) group or control group and then randomly allocated an offender. As this was occurring within the Offender PD Pathway the control group involved were being managed within the Offender PD pathway in probation. The pathway involves basic formulation training for staff. Those in the CF group were provided advanced formulation training and constructed collaborative CFs with their offender. All the participants were then asked to complete a measure of relationship quality. OMs also completed a perceived benefits rating scale evaluating perceived offender engagement and OM confidence. Positive outcomes were reported for the offenders in the formulation group reported significantly higher degrees of trust in their OMs. Likewise, OMs in the formulation group reported significantly higher overall relationship quality, a stronger working alliance and greater confidence.

Knauer et al (2017) examined the impact of consultation and formulation on probation staff working with offenders with personality disorder. Staff ratings were taken on a number of measures: knowledge, confidence, motivation and understanding (of offenders); and satisfaction with management at three stages: pre-consultation, post-consultation, and after receiving a written formulation. The analyses revealed that ratings increased for all the assessed variables after the consultation. There was no further increase after receiving the formulation letter.

Clark & Chuan (2016) conducted an evaluation of the Impact Personality Disorder Project. The intervention involved providing psychologically informed consultation and training to probation officers managing high risk offenders and staff working in two 'approved premises'. Not all offenders had a diagnosis of personality disorder but most had behaviours associated with personality disorder. Baseline data on prison recalls were taken for one year prior to the intervention commencing and for three years after its introduction for 10 regularly available probation officers. Additional data gathered included reasons for recall and evidence of new arrests or charges. The authors found that there was a significant decrease in recalls in the year immediately following the introduction of the intervention. This was sustained over the second year for a smaller number of officers available and into the third year. There was no significant increase in serious further reoffending. Other findings of interest were that 'non-compliance with supervision' as a reason for recall reduced by two thirds. 'Challenging behaviours' were also reduced.

Within this study the intervention was used to provide staff with new perspectives and offer a wider range of options for working with the offender and allow staff to consider the underlying needs driving behaviours. The aim was to help staff to:

- identify personality disorder presentations,
- understand the link between the individual's surface presentation, offending behaviour, developmental history and risk,
- improve offender engagement and sentence planning,
- understand how to access local mental health and other community services and prepare offenders to be ready for these services, feel emotionally contained through acknowledgement and validation of their concerns and emotional reactions to the work. (Clark & Chuan, 2016, p.188)

Most recently, Bruce et al (2017) undertook a preliminary evaluation of an intervention termed 'psychologically informed practice' (PIP) in a post-sentence release hostel in a South London borough. This perhaps has the most relevant publications with regards to inpatient services as it was based in a hostel (PIPe) rather than in an outpatient equivalent setting. They compared staff attitudes and offender behaviours when compared to a similar hostel that did not implement the intervention.

The PIP intervention is described as having four key components (using the acronym SAFE) –

i. *Staff training and support* – essential to meet Government's workforce development
ii. *A psychological framework* – necessary to provide an understanding for staff of what drives and maintains patterns of behaviour; contributes to shared perception and language, erosion of stigma and unification of teams. It also facilitates 'a healthy organisation', characterised by agreed tasks, roles and responsibilities and defined operating principles.
iii. *Focus on relationships* – in this model managed by mindfulness principles. In practice this involves reflective practice, supervision, and regular case formulation. It extends beyond staff and offender to all team members, senior managers and partner agencies

iv. *Evaluation* – essential to assessing value, feasibility and meaningfulness of approach.

In practice this intervention had two phases. The first was an intensive 6-day staff training programme which included a psychological framework for understanding and managing personality disorder, therapeutic alliance training, and knowledge consolidation and application. Secondly it involved ongoing staff support which included supervision, reflective practice, case formulations and 'rapid response' telephone consultation. Initial evaluation at six months found that staff in this hostel had a greater knowledge and understanding of personality disorder and a greater sense of personal accomplishment. For the offender group, the study found lower rates of warnings and recall to prison at 6 months.

Other research also points to the potential usefulness of this approach. Fonagy et al (2009) in a large randomised-controlled trial across a number of schools in the USA compared CAPSLE - a systems and *mentalization* focused whole school intervention - versus regular school psychiatric consultation and TAU. This was as an approach to deal with aggression and bullying in schools. After two years of the intervention, the authors found that the *mentalization* framework moderated the developmental trend of increasing peer reported victimization, aggression, self-reported aggression, and aggressive by-standing, compared to TAU schools.

Clinical Guidelines

In an alternative use of the term Structured Clinical Care, the UCL competency framework for working with Personality Disorder lays out the knowledge and skills required for working with Personality Disorder. They state:

"*Although it can be offered as a stand-alone intervention, generic structured care is not a direct alternative to specific psychological interventions..... but generic structured care may be particularly suitable for clients who are unwilling or unable to commit to the structure and intensity that characterises specific psychological interventions.*

This UCL competency framework encompasses a whole system approach and looks at the patient care experience from assessment and admission into a service through all aspects of care through to discharge. In describing the competencies required to work with personality disorder, it therefore provides a basis for understanding what is required to have a psychologically informed and a personality functioning informed service. As a result, these competencies have some similarities when compared to the RCT controls in that they are describing what needs to happen beyond the treatment room/therapeutic space to create an environment that not only supports therapy but creates a wider therapeutic milieu that can in itself have the potential to be transformative. However they are broader in their scope.

These competencies are developed by UCL in order to make sure that services are responding to patients with personality disorder and their relevant needs. UCL has also developed similar competencies for other types of disorders. It is clear that this is not about an alternative treatment approach; it is about delivering a service that incorporates personality disorder and personality dysfunction into its provision of care, treatment and management. Over and above

that there are many of these competencies that seem to be describing good clinical care which is not just relevant to a service that is responsive to personality dysfunction but to services that are responsive to a range of needs.

Other psychological models too have demonstrated the benefit of consultancy (Carradice, 2013). Nicholson & Carradice, (2002) highlight that within inpatient settings the role of psychologists is not restricted to the provision of therapy and that when working in inpatient setting there is a significant need for indirect working that uses the psychologist as a resource for the team. Work can include formal and informal formulation, training, teaching and looking at strategic issues.

We would see SCC as being concordant with NICE Guidelines for Borderline and Antisocial Personality Disorder (National Collaboration of Mental Health, 2010). Of note, these NICE Guidelines recommend: the development of an optimistic and trusting relationship with patients; the need for structured assessment for some cases; the need for structured care with regards to Borderline PD; the need for training and support for staff for Antisocial PD (See Appendix 2).

The Consensus Statement on Personality Disorder outlines the Core Tenets of an effective Intervention as being:

- developing a consistent therapeutic environment and network of services,
- a consistent and respectful therapeutic relationship in which a real sense of partnership can develop,
- psychologically informed practice,
- individual formulations,
- and a trained workforce

We would see this as being consistent with the Principles and model we are proposing.

Bateman et al (2017) have recently proposed that the three Cs of *consistency, coherence* and *continuity* are essential components of the management of patients with a diagnosis of personality disorder.

John Livesley's staged approach to working with personality disorder was not written for a systems based approach. However they have a wider relevance. In our model, the systems level is attempting to achieve the Safety and the Containment tiers of John Livesley's staged approach (Livesley 2005).

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

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

Professional Practice

The Trauma Knowledge and Skills Framework and *Promoting Excellence* are key NES documents where parallels to this work can be seen. The Trauma Framework highlights the high rates of trauma within the general population and population seeking care from the NHS and the need for services to be responsive to this. The framework distinguishes between services in terms of the degree to which they need to incorporate trauma into their service planning and delivery. This will depend on the degree to which the treatment of trauma is a core aspect of their care. For example, the term 'trauma informed services' is used to describe the baseline at which all services should be operating; trauma-skilled, is used to refer to services that have direct contact with service users who may a history of trauma, whether or not the trauma is known about; trauma-enhanced is used to refer to services that have regular and intense contact with service users who are known to have a history of trauma; and trauma specialist services refers to services who have a direct role through therapeutic interventions and/or consultation for those affected by trauma. There is a well understood link between having a history of trauma and developing a personality disorder. Patients with a diagnosis of Borderline personality disorder have been consistently found to be more likely to have childhood trauma (Herman, Perry & van der Kolk, 1989; Goodman & Yehuda, 2002; van der Kolk, Hostetler, Herron & Fisler, 1994). This development of personality disorder and personality dysfunction is seen to be mediated through the affect regulation problems that result from early trauma. It needs to be acknowledged that we believe there is overlap between the work that would be identified as beneficial to those with trauma histories and the work that we are identifying as helpful when working with patients with personality dysfunction. This identified link between early trauma and dysfunctional personality traits is one reason why taking a trauma perspective when working with patients with forensic histories is both necessary and informative. Promoting Excellence takes a similar approach to dementia within the care of the older adult population, highlighting the prevalence of this disease and the need for services to be responsive to the needs of patients with this disease regardless of whether it is the primary reason for contact with services. In a similar way to this paper, these documents highlight the need for an

informed and trained staff group and the role and impact of the whole service in its interactions with patients rather than looking at discrete episodes of interventions.

Psychological formulation has always been at the core of the work of the clinical psychologist. Recently within the field of clinical psychology there has been an increase in publications highlighting the use and benefit of formulation beyond the realm of direct work with the patient, and stressing the important gains that can be made when using it systemically. For example the BPS document 'Psychological Best practice in inpatient services for older people' (Ross and Dexter Smith, 2017) highlights the range of ways in which psychological practice can impact on patient care. In particular they underline the role of formulation:

Psychological formulation has been found to be effective in three broad areas that are relevant to inpatient care:

1. *Shared recognition and increased empathy for the person (e.g. Kennedy et al., 2003).*
2. *Enhancing the quality of the interventions and care planning (e.g. Moore, 2007; Murphy et al., 2013).*
3. *Increasing capacity within the staff team for safe unknowing and reflection; the ability to tolerate a position of uncertainty in regard to a patient rather than impose a framework or decision that is inadequately developed (e.g. Schon, 1987).*

Ross & Dexter-Smith, 2017, p.40

In addition, The Power, Threat, Meaning Framework (Johnstone, L. & Boyle, M., 2018) was developed as part of a project to fulfil Recommendation 3 of the BPS Division of Clinical Psychology position paper *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift*. This position paper was written in response to the upcoming proposals to revise DSM and ICD classification systems. Recommendation 3 was 'To support work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors' (p.9). The framework places significant emphasis on the role and benefits of team formulation.

The Framework suggests team formulation is probably best understood as a form of staff consultation or supervision, in which 'countertransference, feelings of stuckness, frustration or confusion may be a central focus'. ... Team formulation can also be very helpful if the service user is currently too distressed to talk about their personal history and contexts. (p.107). The Framework also draws attention to evidence from small scale audits and evaluations where staff report a range of benefits, including increased understanding and empathy, more cohesive and supportive team working, reduced team disagreement, improved morale, more consistent intervention plans, and greater hopefulness about the possibility of recovery (summaries in Cole et al., 2015; DCP, 2011). (British Psychological Society, p.108). It also cites emerging evidence that team formulation can reduce staff burnout and incidents of 'challenging behaviour' in service users (Berry et al., 2009; Newman-Taylor & Sambrook, 2012); and can result in significant reductions in service user distress, along with significant increases in their confidence in self-management (Araci & Clarke, 2016).(British Psychological Society, p.108)

In relation to forensic work, the PTM Framework particularly highlights the Offender PD Pathway in England and Wales as an example of good working practice where collaborative formulations are used to enhance management and outcomes. It also underlines the utility of this model for clients that may not be ready to engage but where the formulation can support staff and directing ways of working.

The DCP has also published a special edition of the Clinical Forum on Team Formulation (download at https://shop.bps.org.uk/publications/publication-by-series/clinical-psychology-forum/clinicalpsychology-forum-no-275-november-2015-extended-edition.html) and provided training.

Alongside documents produced from within and by the Clinical Psychology profession, there have been frameworks, guidelines and standards from other disciplines also. One of these that the group was particular interested in was the "Enabling Environments" work produced by the Royal College of Psychiatrists (RCPsych, 2013).This is a integrated set of guidelines, standards and ways to benchmark against these that include directly questioning staff and patients about their experiences of their clinical environment. The vision of Enabling Environments is that they can be either clinical or non-clinical and services can apply for an Enabling Environment Award by demonstrating that they can meet the 10 standards. The aim of this is to create environments that are places where "people can develop, grow and flourish". (p.7)

Such environments, which would include secure services, should be able to demonstrate that there are places where (RCPSych, 2013)

- positive relationships promote well-being for all participants
- people experience a sense of belonging
- people involved contribute to the growth and well-being of others
- people can learn new ways of relating
- there is a recognition and respect for the contributions of all parties in helping relationships

Ultimately, the qualities described above could be seen as core components of a generic SCC approach to life within secure services.

The recent Consensus Statement on Personality Disorder ‘A Shining Light’ (2017) stresses the difficulties in the current approaches to treating personality disorder. It draws a number of conclusions and makes several recommendations. Of particular note for this paper:

- The availability of evidence based interventions is not the whole picture; the early experience of system and social failures impacts on an individual’s ability to engage with services throughout their life.
- However also notes that a range of evidence based interventions should be available

- Both that people who attract a diagnosis of personality disorder are likely to have experienced trauma in the past, and therefore that ' a trauma informed, formulation approach , whole system approach to care is necessary'(p.10)
- Generally there is no need for diagnosis, an individual holistic formulation of risk and need is at the heart of the pathway and drives the sentence plan
- Highlights the progress made in the NOMS Offender PD Pathway – highlights the role of formulation (above) but also the focus on relationships and therapeutic environments

See Appendix 5 for Table from Consensus Statement on Personality Disorder

We see similarities between what has been described in this document and the recent NES trauma framework, i.e. in services where there are more patients with a diagnosis of personality disorder or recognised problems in personality function, there is a greater need for a more personality-informed staff group and interventions/systems set up to deal with this.

Staff Wellbeing

Staff wellbeing and attitudes have been identified in research as potential key outcomes and components of SCC. As Russell (2016) has already highlighted, Moore (2012) has proposed key principles and practices for staff working with clients with personality disorder that are likely to promote resilience, and hence wellbeing, in Personality Disorder services. These can be grouped into the areas of: Staff selection; Training; Support; and Responsive management. Briefly these principles state that:

1. 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.
2. Training should focus on how to work interpersonally with clients who push boundaries to help staff manage inappropriate interactions and set and maintain boundaries.
3. 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.
4. Responsive management includes learning from incidents through reviews. When incidents/crises are managed well then they can enhance resilience.

Staff training, as described above in both the SCC and Moore's framework, is important to help with feelings of wellbeing and to improve attitudes. For example, an evaluation of the Level 1 Knowledge and Understanding Framework for Personality Disorder training in England and Wales showed that immediately post-training staff showed an improvement in levels of understanding and capability efficacy and a reduction in negative emotional reaction. Although after 3 months, capability efficacy had reduced to pre-training levels, 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). The latter, of course, are key requirements for SCC.

Additionally, work by Bowers et al (2006) has shown that when staff have a more positive attitude to personality disorder was associated with improved general health and job performance, decreased burnout, and a favourable perception of managers. Part of the construction and maintenance of a successful SCC environment would involve training staff in ways that can help improve attitudes to patients including those with personality disorder; who often considered to be the most problematic and difficult for staff to securely contain in both the internal and external world. Possessing a better attitude therefore improves staff wellbeing and patient care.

A recent review has found that staff in mental healthcare report poorer wellbeing than staff in other healthcare sectors. Poorer wellbeing and higher burnout are associated with poorer quality and safety of patient care, higher absenteeism and higher turnover rates (Johnson, Hall, Berzins, Baker, Melling & Thompson (2018). This paper highlights the recent interest in this area and the move to find interventions that can be effective. Suggestions in this article include, increased staff levels, training in known areas of need, training managers in leadership skills, effective supervision and improving post incident support for staff. They note the cost to organisations of burnout and that designing interventions that target burnout and improved patient care together may improve the effectiveness and uptake of interventions to reduce burnout by staff.

Staff wellbeing is again highlighted within the DoH/NOMS Working with Offenders with Personality Disorder document. They refer to staff as '*the vital heart of any service for offenders with personality disorder. The skills and resilience of practitioners matters to an organisation, particularly when working with risk.* (p. 112). We would recommend all staff read this Practitioners Guide. The following is a brief summary of key points within the chapter on Staff Wellbeing.

They note that staff working in services for offenders with personality disorder can face substantial challenges in daily work that arise from working with individuals who have problematic interpersonal styles and often as a result problematic behaviours.. Strong opinions and high emotions can arise in practitioners and teams who work with these individuals. In addition unexpected behaviours, high reoffending and poor compliance or drop out rates can be demoralising for staff. Staff can be left feeling puzzled and irritated; frustrated; helpless to help them change; defensive when with them; fearful of upsetting person or getting into argument or; manipulated by the person. The cumulative effect overtime of working with this can lead to an amplification of emotional responses. When we fail to make sense of challenging and sometimes risky behaviours we can be left feeling exhausted.

These feelings place staff at risk of: becoming punitive or hostile; over involved or avoidant. Due to the 24/7 nature of inpatient secure care (or in the community, the reluctance of other services often to get involved with forensic patients) this can lead to staff 'burnout'. Burnout is understood to be the reaction to chronic stress in a workplace where there is numerous direct interactions with others. Maslach's 3-factor conceptualisation of burnout is:

De-personalisation and Cynicism	Feeling Ineffective	Emotional Exhaustion
Negative and cynical attitudes and feelings about offender which can lead staff to view them as somehow deserving of their troubles	Feeling unhappy and dissatisfied about personal accomplishments at work	Physical fatigue and a sense of feeling psychologically and emotionally 'drained' from excessive job demands and continuous stress.

Ultimately staff burnout is unhelpful for staff, who will often require time away from work, as well as patients and organisations. The guide highlights work by Scott (2006) that separates the causes of burnout into three categories:

Job Factors	Lifestyle Factors	Psychological Factors
• Unclear Requirements • High-stress times with No 'Down' Times • Big Consequences of Failure • Lack of Personal Control • Lack of Recognition • Poor Leadership	• Too Much Work with Little Balance • No Help or Supportive Resources • Too Little Social Support • Too Little Sleep • Too Little Time Off • Poor Leadership	• Perfectionist Tendencies • Pessimism • Excitability • Personality • Lack of Belief in What you Do

Suggestions made within the Guide about how to protect against burnout are:

- Peer support and supervision as a priority
- Training in offenders with personality disorder – why they are challenging and management strategies for responding to different presentations
- Realistic expectations about change and what is reasonable and possible
- Humour
- Clarity about the job
- Thinking time – staff need protected reflective time
- Seek feedback – sometimes the only way to get praise to balance the criticism
- Workload – review, prioritise, cut down on 'low-yield' work
- Have a support network in and out of work
- Have a life outside of work
- Learn to relax
- Reflective practice

APPENDIX 2 – National Collaboration of Mental Health Guidelines (commissioned by NICE) for Personality Disorder

Recommendations for Antisocial personality disorder

Developing an optimistic and trusting relationship

- Recognise that a positive and rewarding approach is more likely than a punitive approach to engage people and retain them in treatment.
- Explore treatment options in an atmosphere of hope and optimism.
- Build a trusting relationship; work in an open, engaging, and non-judgmental manner; and be consistent and reliable. [*All points based on the experience of the Guideline Development Group*]

Children with conduct problems

- Group based parent training programmes are recommended in the management of children with conduct disorders. [*This recommendation comes from "Parent-training/education programmes in the management of children with conduct disorders" (NICE technology appraisal 102)*]
- For children 8 years or more with conduct problems, consider cognitive problem solving skills training to reduce the likelihood of developing antisocial personality disorder in adulthood if:
    1. The family is unwilling or unable to engage with a parent training programme
    2. Additional factors, such as callous and unemotional traits in the child, may reduce the effectiveness of a parent training programme. [*All points based on high quality randomised controlled trials*]

Assessment by forensic or specialist personality disorder services

- As part of a structured clinical assessment, consider routinely using:
    1. A standardised measure of severity (for example, psychopathy checklist–revised (PCL-R) or psychopathy checklist–screening version (PCL-SV)
    2. A formal assessment tool such as the historical, clinical, risk management-20 (HCR-20) to develop a risk management strategy. [*All points based on moderate quality cohort studies and the experience of the Guideline Development Group*]

Treatment of comorbid disorders

- Offer treatment for any comorbid disorders in line with recommendations in the relevant NICE clinical guideline. This should happen regardless of whether the person is receiving treatment for antisocial personality disorder, because such people are often excluded from routine care. [*Based on systematic reviews and the experience of the Guideline Development Group*]

Psychological interventions

- For people with antisocial personality disorder with a history of offending behaviour who are in community or institutional care, consider group based cognitive and behavioural interventions focused on reducing offending and other antisocial behaviour. [*Based on moderate quality randomised controlled trials and experience of the Guideline Development Group*]

Multiagency networking

- Service provision for people with antisocial personality disorder often involves a considerable amount of interagency working. To provide the most effective multiagency care, services should ensure that there are clear pathways that:
    1. Specify the various interventions available at each point
    2. Enable effective communication among clinicians and organisations.
- Establish clearly agreed local criteria to facilitate transfer between services and develop shared objective criteria on the comprehensive assessment of need and risk. [*All points based on the experience of the Guideline Development Group*]
- Consider establishing antisocial personality disorder networks; wherever possible they should be linked to other personality disorder networks. These networks should be multiagency and should:
    1. Actively involve service users
    2. Have a central role in training staff
    3. Provide specialist support and supervision for staff
    4. Have a central role in developing standards for clinical pathways and coordinating such pathways
    5. Monitor the effective operation of clinical pathways. [*All points based on a systematic review of cross sectional studies on service organisation and staff and carers' experience and the experience of the Guideline Development Group*]

Recommendations for Borderline personality disorder

The role of psychological treatment

- When providing psychological treatment, especially for people with multiple comorbidities or severe impairment (or both), include:
    1. An explicit and integrated theoretical approach used by both the treatment team and the therapist, and shared with the service user
    2. Structured care in accordance with this guideline
    3. Provision for supervision by a therapist.
- Although the frequency of psychotherapy sessions should be adapted to the person's needs and context of living, consider twice weekly sessions. [*All points are based on high quality randomised controlled trials and the experience of the Guideline Development Group*]

- Do not use brief psychological interventions (of less than three months' duration) specifically for borderline personality disorder or for its individual symptoms outside a service that has the characteristics outlined above. [*Based on high quality randomised controlled trials*]

The role of drug treatment

- Do not use drug treatment specifically for borderline personality disorder or for the individual symptoms or behaviour associated with it. [*Based on moderate quality randomised controlled trial*]

Access to services

- People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis, their sex, or because they have self harmed. [*Based on the experience of the Guideline Development Group*]

Developing an optimistic and trusting relationship

- Explore treatment options in an atmosphere of hope and optimism.
- Build a trusting relationship; work in an open, engaging, and non-judgmental manner; and be consistent and reliable.
- Bear in mind that many people will have experienced rejection, abuse, and trauma and will have been stigmatised. [*All three points are based on the experience of the Guideline Development Group*]

Autonomy and choice

- Work in partnership with people who have borderline personality disorder to develop their autonomy and promote choice by:
    1. Ensuring they remain actively involved in finding solutions to their problems.
    2. Encouraging them to consider different treatments and life choices, and to consider the consequences of the choices they make. [*All points based on the experience of the Guideline Development Group*]

Managing endings and transitions

- Anticipate that withdrawal of treatments, coming to the end of treatments or services, and transition to other services may elicit strong emotions and reactions in service users.
- Discuss such changes with the person (and their family or carers if appropriate) beforehand, and ensure that the changes are structured and phased.
- Ensure the care plan supports effective collaboration with other care providers during endings and transitions, and that provision is made for access to services during a crisis.

- When referring a person for assessment by another service, ensure support during the referral period; agree arrangements for support in advance. [*All points based on the experience of the Guideline Development Group*]

Assessment

- Community mental health services should be responsible for routine assessment, treatment, and management. [*Based on the experience of the Guideline Development Group*]

Planning care in community mental health teams

- Teams should develop comprehensive multidisciplinary care plans with service users (and their families or carers, where appropriate) and share these with service users and their general practitioners. Ensure that care plans:
    1. Identify the roles and responsibilities of all healthcare and social care professionals
    2. Specify short term treatment aims and the steps needed to achieve them
    3. Identify long term goals
    4. Include a crisis plan. [*All points based on the experience of the Guideline Development Group*]

The role of specialist personality disorder services within trusts

- Mental health trusts should develop multidisciplinary specialist teams or services (or both) for people with personality disorders. Teams should have expertise in the diagnosis and management of borderline personality disorder and should:
    1. Provide consultation and advice to primary and secondary care
    2. Provide assessment and treatment services for people who have particularly complex needs or high levels of risk (or both)
    3. Offer a diagnostic service when general psychiatric services are unclear about the diagnosis or management (or both)
    4. Develop communication systems and protocols in different services, collaborate with all relevant local agencies, and ensure clear lines of communication between primary and secondary care
    5. Work with child and adolescent mental health services to develop local protocols for transition to adult services
    6. Oversee the implementation of this guideline
    7. Develop and provide training programmes on diagnosis, management, and guideline implementation
    8. Monitor the provision of services for minority ethnic groups. [*All points based on the experience of the Guideline Development Group*]

APPENDIX 3 – PRINCIPLES OF SERVICE PROVISION

1. All staff are given knowledge and awareness training in Personality Disorder.

2. There is recognition within recruitment procedures that staff in forensic settings will be working with patients with personality dysfunction and that staff who are recruited are motivated to do this work.

3. All services have a psychological framework underpinning clinical interactions, i.e. guiding how we interact with patients and each other.

4. The therapeutic environment has a focus on engagement, managing relationships, collaboration, and clear boundaries.

5. a) All patients have a case formulation that outlines early experiences, the development of personality functioning, and offending behaviours and personality strengths and is kept under regular review.
   b) All patients have opportunity to collaborate with their case formulation
   c) Staff in the care team can contribute to the case formulation
   d) Staff in the care team have access to case formulation and it is available for care planning meetings and risk meetings
   e) Care plans include guidelines on how to interact with the patient on the basis of the formulation

6. Multidisciplinary Reflective Practice Groups are embedded into service culture and ward structure.

7. Clinical supervision is provided for all clinicians and embedded into the service.

8. All services have staff who are trained in psychological therapies that have an evidence base with personality disorder. These therapies should be delivered within a coherent clinical governance structure.

APPENDIX 4 – CHECKLIST IN RELATION TO PRINCIPLES

As part of this development the Working Group had considered whether a checklist may be helpful to help staff to monitor and consider where they are in relation to the Principles When considering the contents of a checklist, the Working Group were also aware of other standards and checklists that exist in relation to therapeutic milieu and care standards. These include the AIMS Standard, CCQI Enabling Environments Standards and Structured Clinical management (Bateman & Krawitz, 2013). The Working Group would consider this checklist as providing some examples of how services could demonstrate that they are meeting the Principles. We do not consider it to be exhaustive as there will be individual variations in service delivery and we would hope that services would be able to provide their own unique examples of responsive service delivery. This checklist was created with the assumption that the basic standards of care that forensic services adhere to, are in place, e.g. MHA legislation, MOP for Restricted Patients, High and Medium Secure Care Standards, etc). We suggest its use could be in audit or service evaluation.

	Action Needed	Still Struggling	Doing Well
Principle 1: All staff are given knowledge and awareness training in Personality Disorder			
Staff have completed training in understanding personality, personality dysfunction and personality disorder			
Staff have completed training on helpful ways to interact with patients with personality disorder & dysfunction			
Staff recognise that the way people act can be a form of communication			
Information leaflets should be available for staff, patients, and families to provide an understanding of personality dysfunction and disorder.			
Staff and service users are supported to communicate effectively			
Principle 2: There is recognition within recruitment procedures that staff in forensic settings will be working with personality issues and that staff who are recruited are motivated to do this work			
Recruitment processes reflect need for staff to be motivated to work with patients with personality dysfunction			
Recruitment processes consider the ability of applicants to work with complex personality dysfunction & disorder presentations			

Recruitment processes consider the ability and willingness of applicants to reflect on their own responses to the clinical work and patients			
Principle 3: All services have a psychological framework to formulate personality functioning			
Service has considered adopting a psychological framework to formulate personality functioning			
Principle 4: The therapeutic environment has a focus on engagement, managing relationships, collaboration, and clear boundaries.			
Clinical staff receive training and support from specialist psychological therapy practitioners in providing basic psychological and psychosocial interventions (including, but not limited to, conflict resolution/de- escalation, engagement activity scheduling, and group facilitation).			
There is a consistent structure or daily routine			
There are regular meetings or groups that include significant numbers of both recipients and providers			
Staff and service users feel listened to and understood by others around them			
Peer-support is recognised, valued and encouraged			
Power and authority are open to discussion			
Staff and service users feel supported by those in authority			
Staff and service users are able to have their ideas implemented, where appropriate			
Staff and service users are involved in planning their own development			
Staff and service users take a variety of roles and responsibilities within the environment			
There are expectations of behaviour and process to maintain and review them			
Staff and service users can describe these expectations and how they are maintained			
Staff working with patients with personality disorder should offer consistency and clarity in their approach. Patients should be given transparent explanations as far as possible regarding the reasons for their actions and decisions.			
Within the supportive therapeutic environment, individual interactions with patients should be guided by a case formulation (see below)			

Principle 5a: All patients have a case formulation that outlines early experiences, the development of personality functioning, and offending behaviours and personality strengths.			
Formulation encompasses development of personality functioning including functional and dysfunctional personality traits			
Assessment of personality should inform formulation, e.g. clinical assessment, screening assessment, formal diagnostic assessment			
Relevant clinicians should be trained in diagnosis of PD			
Clinical teams should have an awareness of previous personality assessments			
Principle 5b: All patients have opportunity to collaborate with their case formulation			
The formulation should be shared with the patient (Where appropriate)			
Principle 5c: Staff in the care team can contribute to and have access to case formulation and it is available for care planning meetings and risk meetings			
The formulation should be accessible and usable to all members of the team			
Formulation or Diagnosis of PD clearly in case-notes			
When patients are discharged, formulation that encompasses personality functioning and how to work with someone in response to this to be shared with receiving agency/unit			
Principle 5d: All formulations are regularly reviewed to incorporate new information			
How patient engages with staff to continue to inform formulation of personality functioning			
Principle 5e: Care plans include guidelines on how to interact with the patient on the basis of the formulation			
The clinical formulation should inform treatment selection and pathway for patients			
Formulation of personality functioning to inform how staff approach and attempt to engage with patients			
Clinical teams may need to develop more formalised guidelines for interacting and working with particularly complex patients.			

The formulation should be used to aid identifying how day to day behaviours and interactions can be understood. They should be translated into tangible treatment objectives and the clinical team should clarify expectations with the patient, including what might indicate change.			
Principle 6 Multidisciplinary Reflective Practice Groups are embedded into service culture and ward structure.			
There are opportunities for recipients and providers to discuss the feelings behind the way people act			
Reflective Practice Group facilitators meet competencies outlined by Forensic Network			
All clinical staff are regularly involved in multi-disciplinary Reflective Practice Groups			
Non-clinical staff are able to access Reflective Practice			
Principle 7: Clinical supervision is provided for all clinicians and embedded into the service			
Staff receive regular managerial supervision from a person with appropriate experience and qualifications			
All clinical staff have access to, and attend clinical supervision			
Supervision should support the implementation of training that staff receive in psychological therapies			
Staff providing psychological therapies have regular reflective supervision with a consistent supervisor			
Principle 8: All services have staff who are trained in psychological therapies that have an evidence base with personality disorder with a coherent clinical governance structure			
Any treatment intervention should be well structured and have a theoretical basis which is coherent to both staff and patient and should have a clear focus			
Psychological therapists should identify the factors associated with personality dysfunction and disorder that would be expected to change during the process of treatment.			
Patients have reliable and consistent appointment times			
Treatment should involve a clear treatment alliance between staff and patient and there should be a range of options, i.e. short term and long term.			

Each unit/community team needs to have access to staff who are trained in a psychological therapy that is suitable for use with personality dysfunction			
The service can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology receive ongoing training and supervision to provide psychological interventions in line with guidance (e.g., NICE, NES).			
Other			
Assessment and formulation of personality disorder should be guided by gold standard level tool and should, where possible, incorporate collateral information from a variety of sources.			
Managers takes responsibility for the implementation of SCC			
There are clear management structures which include opportunities for involvement from recipients and providers			
People with a leadership role are visible in the service			
Everyone is open and responsive to evaluation and learning			

APPENDIX 5 – TABLE FROM CONSENSUS STATEMENT ON PERSONALITY DISORDER

Principle	What I expect now?	How might this work?	What can I expect in 5 years?
1. Shared ownership/Collaborative	My story is known by the people and understood by the people who need to know and they work together. I shouldn't have to keep repeating my story. I shouldn't be stigmatised by my experience.	Public sector to establish a concordat with the individual at the centre to enable interagency communication. Evaluate Service Quality with communication as an outcome.	The Mental Health Dashboard will include quality measures relating to interagency communication and functioning alongside measures recording the effectiveness of communication between service users and providers
2. Formulation/Creative Response/flexibly designed	A person centred, individualised trauma informed formulation of the reason for my Psychological distress that I have co-produced.	The System should agree on a core set of standardised tools and processes for assessing the competencies of all grades of staff in understanding formulation and in supporting the need for positive and safe relationships between staff and users of public services, appropriate to the nature of the service provided (e.g. education, criminal justice, health) paying particular attending to those who struggle to maintain relationships.	As a public health intervention, between the ages of 11 and 16, all children will have the option to create, with support , a formulation driven personal passport outlining their personal preferences for psychological and emotional support, regardless of current contact with mental health services This will be recognised as an official document by all public bodies. It would be used and/or developed at first point of contact with mental health services and continue to be developed over the lifespan to support population psychological health and continuity of care. Digital technologies will be central to this development.

Principle	What I expect now?	How might this work?	What can I expect in 5 years?
3. Relational Practice / Connected	People supporting me understand that relationships are central to my life and the relationship with public services plays a part in keeping me safe	All organisations with the Public Sector develop a simple multiagency guide to help support relational practice and the development of psychologically safe and supportive service relationships. Psychologically informed environments should be developed with strong clinical leadership to overcome difficulties and to offer appropriate support and supervision.	All public sector organisations have integrated into their governance processes key performance indicators measuring the quality of psychologically informed practice.
4. Sustainable Long Term Planning	I have a right to be able to access a lifelong service pathway which is age appropriate for my psychological health	The development of a Pathway for psychological health and wellbeing spanning prevention and intervention across all public agencies.	Cross party communication and consensus to develop an integrated psychological health pathway across the lifespan working with all professional bodies and aligned with other longterm government strategies. This should be subject to public consultation and engagement and be integrated into workforce planning.

Principle	What I expect now?	How might this work?	What can I expect in 5 years?
5. Right Treatment / right place / right time	I have the right to receive evidence based treatment s delivered from a suitable venue in a timely fashion from services that offer an integrated approach to my care throughout my life.	Co produced training for evidence based intervention should be offered to staff. Regular supervision should be available to all staff delivering evidence based intervention. Meaningful outcomes should be collated by services. Monitoring of instances of harm due to poor service delivery ("iatrogenic harm") should be routine.	Fragmentation of service delivery is reduced across the life course. Staff possess appropriate skills and competencies in evidence based treatment. Incidences of iatrogenic harm are reduced.
6. Supportive / competent / reflective staff	Competent and supportive staff.	Staff are more self-reflective and supported.	Services will have developed a culture of compassion and reflection to support staff.
7. Culture change / changes to the label "Personality Disorder"	I have a right to be treated with respect and offered appropriate interventions according to need rather than it being based solely on a diagnostic label.	High level work undertaken to review the use of the diagnostic label to offer recommendations for change across agencies. Actively engage in mechanisms to bring about attitude change i.e. media campaigns.	Greater understanding amongst the general public and changes in the culture of services and the attitudes which staff have towards people given a diagnosis of personality disorder.

This Table appears in the Consensus Statement on Personality Disorder (pp15-16) as Table 1, entitled: Meeting the Challenge: What Should People Given A Diagnosis Of Personality Disorder Expect? *(Shining lights in dark corners of people's lives, 2017)*