SECTION ONE

Theoretical Background
INTRODUCTION

A good deal is already known about personality disorders. There is also an increasing understanding of what is helpful and unhelpful for people with these disorders. It is therefore important to communicate this knowledge to the increasing numbers of staff, in a wide range of agencies, with whom they come into contact.

With a few notable exceptions, clinicians have for years tended to avoid involvement in the treatment and support of people with personality disorders. Tolerance of these attitudes is rightly declining. This change in attitude has been well supported by new Guidance from the National Institute for Mental Health in England (NIMHE, 2003a, 2003b) developed in the wake of the National Service Framework for Mental Health (Department of Health, 1999). Relatively small sums of new national money have been used to stimulate the growth of new and sometime novel services. As well as service development, training for staff is becoming a higher priority.

Despite these encouraging developments and changes in attitude there is a long way to go. People with personality disorders are still one of the most socially excluded groups in our society. Their experience of services from a wide range of agencies demonstrates a lack of tolerance and awareness of their issues and of them as individuals. Other chapters in this book aim to help redress the situation by offering readers an opportunity to be more
aware of personality disorders, the people who experience them and the techniques and support systems that can help them.

BACKGROUND

Recent initiatives from the UK government to improve services for people with a personality disorder have raised the profile and the importance of staff training for a wide range of staff engaging with patients with these problems. No longer can training be the preserve of a minority of interested professionals. Rather, it will need to move centre stage for a much wider range of people, in many different agencies. An appreciation of current thinking and the development of best practice is important for anyone involved in delivering community-based services. In particular, working with people with personality disorders is likely to become an essential area of required expertise for Community Mental Health Team (CMHT) members.

The competencies required for working with people with personality disorders are in many respects similar to those needed to work with other individuals with a range of mental disorders. However, there are some clear differences. Direct professional involvement in the area of personality disorders demands a high degree of personal resilience, the ability to maintain good boundaries and manage hostility and conflict. Individual members of staff also need to be multi-disciplinary team players and be able to appreciate the value of team working and support. Just as important is the ability to tolerate and manage the emotional impact on the multi-disciplinary team’s functioning that intensive working with people with a personality disorder can create.

Recent work by the National Institute for Mental Health England (NIMHE) has begun to firm up the agenda for staff training and suggests an integrated ‘Skills Escalator’ as the most effective framework for staff training and development.

This chapter will:

- discuss the context for the recent government and NIMHE initiatives to improve services for people with personality disorders
- outline these initiatives, particularly those related to staff training
- reflect on how these initiatives could help CMHTs work more effectively.

Taking this training and development framework forward is perhaps one of the most critical areas of mental health services in which progress needs
to be made nationally. Without such progress, people with personality disorders will remain one of the most excluded groups of individuals, will be denied relevant and sensitive services, and will continue to be vulnerable in our society. This is a future that ought not to be contemplated in 21st century Britain.

A FRAMEWORK FOR REFORM

The National Service Framework for Adult Mental Health (NSFMH) (Department of Health, 1999) describes a clear set of responsibilities. These responsibilities focus particularly on the provision of evidence-based and effective services for all people with mental disorders, including those with personality disorders (who are debilitated and excluded as a result). As part of the practical implementation of the NSFMH, in January 2003 the National Institute for Mental Health in England published Personality Disorder: No Longer a Diagnosis of Exclusion (NIMHE, 2003a). The guidance was intended to build on standards four and five of the NSFMH, and to ensure the development of specific services for people with personality disorders.

The guidance started from the premise that personality disorders are common and often disabling conditions. Many people with personality disorders are able to manage their lives and relationships successfully on a day-to-day basis. However, there are a significant number of individuals who suffer a great deal of distress. These individuals often receive few or no tailored services and their interactions within their social and their service networks are frequently dysfunctional, and unsatisfactory to themselves and the people to whom they try to relate. Few National Health Service (NHS) organisations and even fewer of the other potential service-providing agencies have specific services for people with personality disorders. In 2002 only 17 per cent of NHS Mental Health Trusts provided a dedicated service for people with a personality disorder (NIMHE, 2003a). The situation is compounded by the fact that even where there is dedicated provision, the services are based on widely varying and occasionally conflicting therapeutic models and approaches. As a result, people are frequently treated or supported at the margins—for example, in Accident and Emergency departments, through inappropriate admissions to psychiatric units, lost in a CMHT’s caseload or as frequent and unsatisfied attendees at a GP’s surgery.

Underlying this unsatisfactory state of affairs is the belief amongst many mental health and social care professionals that there is nothing that people with a personality disorder can be offered that would help them move...
towards recovery and an improved ability to cope with everyday life. The guidance also highlighted the danger that the proposed changes in the draft Mental Health Bill would emphasise even further the enormous gap in services and skills by removing the so-called ‘treatability test’, which has been frequently used as a way of excluding individuals from treatment, particularly by mental health service providers. In effect, some of the most damaged and excluded people in society are refused treatment because individual clinicians make decisions based on their view that people with a personality disorder will not respond to any interventions they have at their disposal. This process of exclusion is legitimised by the current Mental Health Act, which specifies that an individual must be deemed to be treatable before treatment is offered.

Clearly, this was not a position that could continue if the government’s commitment to modernise services was to be delivered. Not only was new investment needed in direct service provision, but also a major initiative was required to provide new training opportunities to ensure that not only clinicians and practitioners but also staff in a wide range of agencies had access to training, ranging from ‘awareness training’ to specific high-level treatment skills.

In summary, Personality Disorder: No Longer a Diagnosis of Exclusion (NIMHE, 2003a) recommends that services should:

- Assist people with personality disorder who experience significant distress or difficulty to access appropriate clinical care and management from specialist mental health services.
- Ensure that offenders with a personality disorder receive appropriate care from forensic services and interventions designed both to provide treatment and to address their offending behaviour.
- Establish the necessary education and training to equip mental health practitioners to provide effective assessment and management.

Translating these specific aspirations for personality disorder services into action on the ground has become one of the major challenges for mental health and other services providers, trying to deliver the spirit and the targets set out in the NSFMH. However, the publication of the guidance, the promise of new money and the setting of specific delivery targets for the NHS has led to a focus on these services as areas where performance improvement is expected by the Department of Health, NHS Trusts, Strategic Health Authorities and Primary Care Trusts. This in turn has stimulated a number of developments aimed at improving services, and appears to have introduced tentative discussions about ‘recovery’, aligning
clinical and organisational responses to people with personality disorder to the mainstream of modern mental health policy and development.

Amongst the developments are 11 new, community based services funded by the Department of Health. These new services are very diverse. Some are to be provided within specialist mental health services, others will be run directly by service users and another group will be delivered through local voluntary organisations. The client groups being targeted through these new services are equally diverse. They include young people, adults and those who have severe substance misuse problems. It is hoped that with the establishment of these new services, and their subsequent independent evaluation, there will be a significant shift upwards in the evidence base about what works and what does not work in treating and supporting people with personality disorders. The evaluation of the bids to provide these new services has had close involvement from a national service user reference group. This group was instrumental in making the final choices and their opinions genuinely weighed as heavily as those of their colleagues from the statutory agencies. After such a positive experience, it is hoped that the pattern of closer involvement of service users in developing and evaluating services will become the norm for services to people with personality disorders, which in the past it certainly has not been.

THE TRAINING GAP

The key to delivering new services and transforming the response of existing mainstream mental health and social care services for people with personality disorder is the development of a workforce that is more aware of the issues that affect people with personality disorders and the way they react to them. This should be a minimum requirement affecting staff in many agencies, both statutory and voluntary, which provide a wide range of essential services including housing, emergency and primary care, employment and benefits advice. Developing personality disorder awareness is important if staff are to better understand the behaviours and attitudes with which they may be presented from time to time, and be able to respond more effectively. It is also a vital ingredient in challenging the stigma that is associated with the diagnosis of personality disorder. To date, that label has more often than not resulted in the exclusion of people from help and support, and has restricted their ability to participate properly as full members of society. The weight of stigma is still a major obstacle for individuals attempting to seek help with their problems. It is fuelled to a large extent by the absence of personality disorder perspectives in
mainstream professional training. This difficult and perverse position is summed up well by the following observation: ‘In Britain we have the remarkable phenomenon that large numbers of quite severely disordered people who require considerable therapeutic effort are deemed untreatable’ (Gunn, 2000).

Although a vital component of service reform, personality disorder awareness is not of itself sufficient. There is also a need for some staff groups to develop new ways of working with people with personality disorder, drawing on the currently small but expanding evidence base, to find ever more effective interventions and support mechanisms. These staff groups are in a wide range of agencies and often in roles not traditionally associated with delivering services to people with personality disorders. In the background survey work carried out prior to the development of Personality Disorder: No Longer a Diagnosis of Exclusion, groups other than those traditionally associated with delivering services to people with a personality disorder emerged as high priorities for new training initiatives. These groups included health visitors, district nurses, junior doctors in Accident and Emergency departments and local authority housing officers. New ways of delivering training to these groups need to emerge and existing training technologies need to be adapted to meet what is a growing need, which will translate into a growing demand for relevant, accessible and high quality training programmes.

**TRAINING INITIATIVES: THE NATIONAL CONTEXT**

The new service developments for people with personality disorders are taking place in a rapidly evolving mental health training and educational context. This evolving context includes new structures and partnerships, as well as the arrival of new players. Key to these new programmes and partnerships are the Regional Development Centres of NIMHE. Each of the regional offices has the responsibility to work with a broad range of local agencies delivering services to people with personality disorders, and has been given funding to help move the training and development agenda forward.

The regional initiatives already underway comprise a wide range of approaches and objectives. For example:

- pilot ‘personality disorder awareness cascade’ courses
- mapping of existing training programmes
- development of multi-stakeholder training specifications
• development of CD-ROM and internet-accessed training packages
• tailored training for primary care staff.

In addition to developing tailored training packages that reflect local need, there is much still to be done to embed awareness of personality disorders into the pre- and post-registration education. Key targets are clearly professionals working directly in therapeutic relationships, but also other professionals who come into contact with people with a diagnosis of personality disorder, including GPs and other primary care staff. This breadth of approach is vital if effective and co-ordinated support networks for individuals are to be established.

There is evidence of an encouraging recognition of the need to change both pre- and post-registration training to incorporate the dimension of personality disorder, by several of the key national registration bodies. These include the Royal College of Psychiatrists (RCoP), the British Psychological Society (BPS) and the Nursing and Midwifery Council (NMC). There is also growing enthusiasm from organisations such as the Prison Service, which at any one time has custody of large numbers of people with personality disorders and whose staff are often ill equipped to develop or deliver a productive set of interventions.

It is also important to acknowledge that whilst good quality, multi-disciplinary training is in short supply it does exist. There are some examples of existing good practice, including well established training programmes, manuals and other training materials. These at least represent a foundation for future national, regional and more local developments and consideration needs to be given to how best to apply these tools to new and wider audiences. One possibility which has been discussed is the development of a ‘capability benchmark’ process for these products and programmes, which would act in the same way as the quality kite mark in ensuring consistent standards. The benchmark process would be led through NIMHE and its education partners. Assessing the quality of existing training programmes and media will be an important first step.

When there so obviously remains a great deal to be done, with new programmes and media to develop, it is easy to start re-inventing the wheel and fragmenting the development programme. Whilst needing to avoid such fragmentation, one area that requires immediate attention is the involvement of service users in the development and operation of training programmes. A key characteristic of the national development programme running through the NIMHE regional offices has been the close involvement of service users. It is important that this pattern is reflected as other agencies and initiatives move into this area of work. The involvement of service users must go far
beyond the traditional representational and consultative roles and engage with the training needs of service users themselves and their involvement in the delivery of professional and awareness training.

**A NATIONAL TRAINING FRAMEWORK**

There is a need for exponential improvements and increases in training availability to secure improved services and learn from new developments and evidence. If this is to be delivered consistently around the country, it requires a framework to which people can refer and through which people can make sense of the various other training initiatives, related to current general mental health service developments. In order to provide such a framework, NIMHE carried out a detailed piece of development work involving a wide range of experts, including service users. The result was the publication of *Breaking the Cycle of Rejection: the Personality Disorder Capabilities Framework* (NIMHE, 2003b). The framework highlights some of the critical capabilities that are appropriate to interactions with people with personality disorders and that are required by staff at all levels and in a variety of agencies. The framework was not designed to be a definitive work. Rather, it describes a process which will be enhanced and changed over time as knowledge expands and services develop. The framework builds on a number of basic principles that are designed to break the ‘cycle of rejection’, which is the experience of many people with personality disorders. It starts from the premise that developing responsive and sensitive services for people with personality disorder is possible and will promote social inclusion and deliver better outcomes.

The underlying principles of the framework are that training:

- should be based on respect for the human rights of service users and their carers
- programmes should consider how best to reflect the views and experiences of service users and carers
- should be aimed at breaking the cycle of rejection at all levels, including self-rejection, the social support system, practitioners and the wider health and social care systems
- should encourage service user autonomy and the development of individual responsibility
- should be multi-agency and multi-sectoral
- should support team and organisational capacity as well as that of individual practitioners
• should be connected to meaningful life-long learning and skill escalator programmes
• should be based on promoting learning in approaches to treatment and care that are supported by research evidence, where it exists.

These principles were derived from *Personality Disorder: No Longer a Diagnosis of Exclusion* and from the work of an expert advisory group and a service user focus group. The aim of the framework is to identify the specific capabilities required of staff working with people with personality disorders in a range of agencies and delivery settings, and to relate these to the various stages of an individual’s career development. The framework is built around identified points of a user pathway. These key points include:

• access and referral routes
• interventions and treatment episodes
• recovery and stepping down from treatment.

The framework looks to staff being able to access training through innovative, multi-disciplinary training courses linked to their career progress. This approach will help to create a workforce with a much better understanding of personality disorders and who are more aware of the impact of these disorders on families, individuals, agencies and the wider society. In turn, the aspiration is that such a workforce will act more appropriately, compassionately and be less judgemental to behaviours that are often hard to understand and difficult to tolerate. This trained workforce should be able to work more confidently with people with a personality disorder in multi-disciplinary teams, delivering increasingly better evidenced interventions and supports. This better trained and more aware workforce will also be able to support and empower those who use services. They will help individuals to achieve their full potential and in so doing break the cycle of rejection which characterises so much of the negative and rejecting attitudes and practices of so many agencies.

The *Personality Disorder Capabilities Framework* describes the qualities and skills required by individuals working in primary, secondary and specialist services and also in the wide range of other community agencies that people may contact. The framework encompasses:

• ‘performance’—skills that practitioners need to have and how they need to use them in their work
• ‘ethics’—integrating values and social awareness into professional practice
• ‘reflective practice’—effectively implementing evidence-based practice and review, and learning from outcomes
• ‘commitment to life-long learning’.

The framework is built on the assumption that different staff in different organisations may well need different ‘levels’ of the same capability, linked to their roles and functions in a given service. To do this, the framework introduces the idea of the ‘skills escalator’. This enables the development of valued career pathways in working with people with a personality disorder. It recognises that in common with many other areas of health and social care some of the interaction most valued by service users is undertaken by people with no formal professional qualifications, and indeed by service users themselves. The wide range and complexity of concerns and needs presented by people with personality disorders requires a well co-ordinated multi-disciplinary and multi-skilled approach. Inevitably, some of these staff will work outside the specialist mental health sector, or indeed local authorities and the NHS more generally. These individuals also need an appropriate level of understanding and skills in engaging, communicating with and delivering the services and support of their agencies to people with personality disorders.

The framework also proposes that managing teams, and the leadership of organisations providing services to people with personality disorders, is a critical area of capability. In the absence of this leadership capability, there is likely to be a high level of burn-out, absenteeism, sickness and disillusionment in teams working with people with personality disorders. The framework outlines the sort of management capabilities required to support staff and sustain services. The framework identifies the capable organisation as being key to staff becoming and remaining effective. It defines the capable organisation as being one that requires:

• operational models that can respond to the complexity of the needs presented by service users
• ease of access to appropriate levels of treatment and support
• the development of standards for multi-disciplinary service delivery
• cross-boundary and cross-agency agreements to support the movement of service users away from dependency on services and towards proper social inclusion
• consistent support for staff teams
• access to supervision, education and training.

The framework emphasises that all the above must be underpinned by a culture aimed at sustaining learning. The capable organisational model has
implications for the way learning opportunities are delivered and sustained. The boundary between training, practice development and supervision is not a clear one, and each of these dimensions has a role to play in growing and sustaining the professional development of staff.

Probably the most critical aspect of the framework, which, though harrowing, gives cause for optimism, is the fact that it leans heavily on the experiences of people with personality disorder who are contemporary users of the very variable services currently available. It is designed around the user pathway into, through and out of service. It highlights the staff capabilities needed at identified points on the user pathway and it relates the type and level of training required by different staff if they are to develop those capabilities. The framework emphasises that in order to work positively with people with personality disorders, it is essential to have an understanding of the causes and the consequences of these complex conditions. The debate has been clouded over recent years by the close connection made by many politicians and sections of the media between personality disorder and dangerousness. Whilst there clearly are dangerous people who have personality disorders, the numbers are small. It is much more common for people with personality disorder to be highly vulnerable to abuse and the experience of violence, and to self-harm and suicide. ‘We have been damaged, often early in life and we have grown up with mistaken beliefs about ourselves. For these reasons we have difficulties with relationships because we often believe that we are unlovable and we are very sensitive to rejection. For that reason we need easier and known access to services’ (quote from a service user in Personality Disorder; North Essex News, 2003).

The framework starts from this user viewpoint and identifies four domains of capabilities:

- promoting social functioning and obtaining social support
- improving psychological well-being
- assessing and managing risk to self and others
- management and leadership.

Each of these domains is related to four career stages:

- pre-employment
- vocational education
- professional training
- continuing professional development.
The framework details what expectations there should be of the training and skills required to operate as a capable practitioner at each of the career stages and for each of the domains of capability.

**THE SKILLS ESCALATOR**

The *Capabilities Framework* builds on the concept of the ‘Skills Escalator’. Modern NHS human resource practice is predicated on organisations committing to give people without professional qualifications, or who work at relatively low skill levels in the NHS and other heath and social care settings, the opportunity to progress to roles requiring professional levels of training and qualification. The model of the skills escalator puts in place what are termed ‘stepping-on points’, cadet schemes, role conversion, back-to-work schemes and ‘stepping-off points’, to enable existing staff to move progressively on to more demanding and complex roles. The escalator approach opens up opportunities for groups of staff whose developmental needs have been overlooked. It acknowledges that life and experiences from other work settings can be just as valuable as more formal pre-professional training and experience. It enables organisations to draw in people with the right personal attitudes and attributes needed for work within new services, rather than focussing exclusively on their professional or academic achievements. It also offers a way out of career ruts for existing staff. The development of a career escalator for work in personality disorder services opens up the opportunity for a more strategic and integrated approach to workforce recruitment, retention and development. It also encourages innovative approaches to recruitment that are more likely to draw in people with the personal attributes required for work within new services for personality disorder rather than the current focus on professional qualifications.

**COMMUNITY MENTAL HEALTH TEAMS AND THE CAPABILITIES FRAMEWORK**

What relevance do the new initiatives in services for people with personality disorders have for community mental health teams (CMHTs) and their individual staff members? Is there any relevance to CMHTs of the *Capabilities Framework* and the skills escalator? The answer to both questions is, unequivocally, yes. The reason why, and some of the practical applications, are explored in the remainder of this chapter.

CMHTs are at a crossroads in their development and their role in the delivery of modern mental health services. Since the post-NSF...
investments and developments in mental health services, there has been a sharp increase in specialist teams delivering services to some service users and in some of the service areas previously covered by CMHTs and indeed in-patient services. These include:

- assertive outreach
- early intervention in psychosis
- crisis resolution and home treatment
- primary care outreach.

These and other initiatives have expanded the capacity of the mental health services but have also forced a re-appraisal of the role of the CMHTs. The NSFMH and subsequent implementation guidance strongly support the CMHT as the gateway into services. However, despite this assertion there is not even today universal coverage by CMHTs in England. There are clearly defined models and structures for the teams, but there is little consistency in their actual make-up and role on the ground.

Added to the demands on CMHTs is certainly going to be a greater involvement in delivering and co-ordinating services for people with personality disorders. CMHTs should and frequently do operate at the interface with other agencies, delivering services to people experiencing mental distress. No group of people consistently stands at these complex interfaces more than people with personality disorders. In addition, even without the passage of a new Mental Health Act, there is a growing recognition that it is wholly unacceptable that a large group of individuals who have clear, complex and unmet needs for treatment and support can be ignored because of institutional prejudice and the stigmatisation of personality disorder. Given that many if not most of these individuals require support and treatment in the community, the CMHT will inevitably become a key player in delivering expanded services and new approaches to treatment.

How can the Capabilities Framework help? There are a number of ways the framework can be used at a team and individual level, both as a capabilities assessment and a training tool and as a staff and career planning methodology. There are also other approaches in the framework, such as reflective practice, which will help improve the functioning of the team and its individual members. These are examined in more detail below.

The framework is initially best used by the CMHT as an assessment tool to:

- Initiate whole team workforce planning for their involvement with their patients with personality disorder.
Develop targeted training for specific individuals or groups within the team who may take the lead in co-ordinating or delivering the team’s work in respect of personality disorder services.

Align career and training pathways for individuals who wish to become more specialist in this area of work.

Align the continuing professional development of individuals and the team as a whole.

Examine and strengthen the team’s management capacity.

Engage service users in a dialogue about service needs and, where possible, find ways of involving them in the training and development of the team.

Application of the framework in this way will stimulate the team to look more closely at its functioning across the board, since much of the analysis of the team’s and individual’s functioning in respect of services to people with personality disorder will be reflected in attitudes and ways of working with other groups.

A further and equally challenging way of using the framework as an assessment tool is to examine the work and capacity of the team under each of the capability domains, for example the following.

**PROMOTING SOCIAL FUNCTIONING AND OBTAINING SOCIAL SUPPORT**

- Does the team have a clear understanding of diversity, differences and rights and apply them to people with personality disorders, and support other staff in maintaining positive and respectful attitudes?
- Is the team capable of contributing to the development of positive strategies for challenging stigma and for promoting social inclusion in partnership with service users?
- Is the team geared up to support the personal and social networks of service users and their carers?
- Is the team able to advocate on behalf of service users and their networks in the wider organisation and with other agencies?
- Is the team and its members capable of boundary maintenance and able to support each other in this often challenging area?
- Is the team robust enough to support the challenge of reflective practice?

**IMPROVING PSYCHOLOGICAL WELL BEING**

- Is the team capable of applying a critical understanding of theories of personality disorder?
• Is the team or at least some of its members capable of the clinical assessment of personality disorders and other mental health needs, using standardised measures and contributing to the formulation of treatment and support plans?
• Is the team capable of applying case formulation techniques?
• Is the team capable of establishing and maintaining productive long term therapeutic relationships with service users with a personality disorder and supporting staff in maintaining demanding therapeutic relationships?
• Is the team and its members capable of tolerating frustration and anxiety?
• Is the team capable of working accountably within its organisation and aware of the impact on the team of working with people with a personality disorder?

**ASSESSING AND MANAGING RISK TO SELF AND OTHERS**
• Is the team capable of undertaking actuarial risk assessments, particularly understanding the risk of offending behaviour, or harm to self or others?
• Can the team undertake dynamic risk assessments focused on cognitive and inter-personal factors, substance misuse and lifestyle indicators?
• Could the team undertake a family and community risk assessment?
• Is the team capable of collaborating with multi-disciplinary and multi-agency risk management plans?
• Is the team capable of planning and delivering interventions based on case formulation addressing specific risk factors, providing proposals for risk management and for motivating individuals?

**MANAGEMENT AND LEADERSHIP**
• Is the team capable of bearing hostility and aggression without retaliation?
• Can the team reflect on its own and others’ reactions to clients and offer considered responses?
• Can the team maintain personal and professional boundaries?
• Is the management of the team capable of providing professional support and supervision to individuals?
• Can the team provide support and advice to other agencies who are trying to cope with clients with personality disorder?
• Is the team capable of working across agency boundaries to ensure seamless services?
• Is the team capable and willing to embrace service change, develop positive partnerships with service users and promote social inclusion and challenge rather than contribute to stigma?
Another way that the framework can be used is to develop reflective practice. People with a personality disorder can behave in ways that seem to invite reaction. They may, for example, appear to think that no help is ever any use, they can be hostile, they may be demanding. At times they will sabotage all attempts at constructive help. These behaviours can be frustrating, particularly for the hard-pressed CMHT member. Particular skills and knowledge are needed to help practitioners understand the reasons for these behaviours and to rise above the frustration and understand the reasons behind the presentation. This means that judgemental and impulsive responses cannot be indulged in, however pressed or testing the situation. The key to moving forward is to reflect calmly and with the support of other team members about what may be happening and what triggers may have been activated. Practitioners who have this capability and level of professional maturity can maintain the critical focus on the underlying needs of the service user. They will also be able to sustain the effort required to assist the individual in developing less destructive ways of managing their difficulties. These skills can be learned and are useful for all staff working in CMHTs, but they are essential for anyone working with people with personality disorders. Without them, staff will be unable to support service users in coming to terms with and managing the range of social and personal resources that are fundamental to good mental health.

CONCLUSION

No mental disorder carries a greater stigma than that of personality disorder. Those diagnosed with a personality disorder feel labelled by professionals, the media and by society at large. Personality disorder is equated in the minds of many professionals with untreatability. Recently, the media and some politicians have almost made the terms ‘dangerous’ and ‘personality disordered’ synonymous. Those with personality disorders are often characterised as time-wasters, manipulative and attention-seeking. Their feeling is often that they are blamed for their condition. In this climate, there is a pressing need to drive through the reform and modernisation of society’s and service agencies’ perceptions of and relationship with individuals with personality disorders.

It was clear from the work underpinning Personality Disorder: No Longer a Diagnosis of Exclusion (NIMHE, 2003a) that there are not enough services available for people with personality disorders, nor is there
sufficient awareness of their needs and how best to ensure equity of access to other health and social care services. Staff in most health and social care agencies have little or no awareness, experience or training in work with these individuals.

The government, as part of its attempts to modernise mental health services, has published through NIMHE two guidance papers, aimed at kick-starting the process of reform. There has also been new investment in pilot services in community and forensic services and in the acceleration of training initiatives. There is evidence that these investments are beginning to bear fruit, shown by a revived interest from strategic health authorities, NHS trusts and primary care trusts in the enhancement of services targeting people with personality disorders. These developments are of course welcome, but form only the embryos of what will need to be a major programme of training and investment if we are to develop humane, 21st century services.

CMHTs are at the interface of a wide range of services that people with a personality disorder seek to access. To date, the response of many CMHTs has been as described. The advent of new investment in additional specialist community teams has meant that CMHTs need to re-evaluate their role. In doing this, they should acknowledge the pressing case of people with personality disorders. It is inevitable that as the pressing case to improve services to people with personality disorder grows in strength CMHTs will be drawn inexorably into intervening and providing treatment and support for people with personality disorders. Few teams will currently be equipped either from a skills or a team management point of view. The new Capabilities Framework gives an excellent starting point for teams to review their current performance and to formulate plans to develop their responses. In addressing the issues that would enhance performance, capacity and skills in respect of personality disorders, CMHTs will find that they are laying the ground for a clearer identity as deliverers of mental health services and as advocates and intermediaries for all their clients. This re-evaluation of each team and individual’s role within the overall constellation of health and social care can only lead to improved performance. It is hoped this will lead to a vastly improved experience and outcome for all service users. This is something that is surely the goal of every practitioner and agency delivering health and social care services.

REFERENCES


