KENT PUBLIC HEALTH OBSERVATORY

Personality Disorder Needs Assessment

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Conduct disorders can occur early in infancy at a similar rate as later in childhood. Children who experience negative parenting, poor quality relationships and other adversity in early life

1. *Executive Summary*

1.1 Introduction

This needs assessment takes a life course approach to describe the prevalence of personality disorders in Kent. Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships.[1] In a British Psychological Society report, personality disorders (PD) were described as extreme variants of normal personality that are associated with significant dysfunction or distress and wide-ranging adverse consequences, such as suicide, self harm, addiction, family breakdown, prison and social exclusion.[2] Alongside the personal distress and social challenges of PD, there is a significant economic cost to society in areas such as poor educational attainment, service usage, contact with the criminal justice system and unemployment.

Many people with personality disorder present with conduct and associated disorders in early childhood: up to 50% of children and young people with a conduct disorder are diagnosed as adults with a personality disorder [See Chapter 4]. The younger the child presents with a conduct disorder the greater their risk long term.[3] Adequate prevention interventions are needed as early as possible such as support for parent child bonding, family support and transition services as part of a life course approach. It will be important to read this report in conjunction with the Child and Adolescent Needs Assessment.

The projected costs of PD to the UK economy in 2026 will be £12.29 billion.[4] Preventing conduct disorders in children who are most disturbed would save £150,000 per case in lifetime costs and promoting positive mental health in children with moderate mental health would produce a lifetime benefit of around £75,000 per case [See Page 65] .[5]

A more responsive and effective pathway for personality disorder to offer better continuity of care is needed in Kent to support this challenged community. Care pathways should be reviewed to ensure equity of access for men and women, and to ensure that they are robust enough to accommodate a chaotic lifestyle and the challenges of dual diagnosis.

1.2 A Summary of the Key Facts derived from this Needs Assessment

Deprivation

- *PD is linked to deprivation. There is a linear relationship of more admissions from Kent's more deprived communities [Page 24].*

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Children and Adolescents

- *Prevalence among children is also linked to deprivation, with a 3- to 4 fold increase in prevalence among children from more deprived households compared with those in the most affluent [Page 59].*
- *Nationally one in ten children aged between 5 and 16 years has a clinically diagnosable mental health problem. About half of these (5.8%) have a conduct disorder, and 1–2% have severe attention deficit hyperactivity disorder (ADHD). Both are associated with PD in adults.* [6]
- *Common child psychiatric disorders and, in addition patterns of comorbidity among them in early years are similar to those seen in later childhood.* [7]
- *Conduct disorders are the most common mental disorder in children and young people and half go on to have antisocial behaviour disorder (ASPD) as adults.*[8]
- *Conduct disorder in childhood is also associated with a 70 fold increased risk of being imprisoned by the age of 25.*[9]
- *The most antisocial 5% of children aged 7 years are 500% to 1,000% more likely to display indices of serious life failure at 25 years, for example drug dependency, criminality, unwanted teenage pregnancy, leaving school with no qualifications, and unemployment.*[10]
- *NICE notes that almost 40% of looked after children, those who had been abused and those on child protection or safeguarding registers have a conduct disorder [Page 63].* [11]
- *The National Institute for Health and Clinical Excellence (NICE) research evidence for working with children and young people at risk of PD, and their families, stresses the value of preventative measures in childhood. A good start in life and positive parenting are fundamental to good mental health and wellbeing and to lifelong resilience to adversity.* [12] [13]

Adults

- *In the UK, it is believed that between 4.4% and 5.7% of the adult population has a personality disorder.*[14] *Extrapolating the national data to Kent, there were an estimated 5,438 people aged 16-74 with personality disorder in 2014.*
- *Between 50% and 78% of adult prisoners are believed to meet criteria for one or more personality disorders, and even higher prevalence estimates have been reported among young offenders.*[15] *NICE notes that criminal behaviour is central to the definition of antisocial personality disorder, although it is often the culmination of previous and long standing difficulties, such as socioeconomic, educational and family problems.*
- *In Kent, national predictions show that the PD population is likely to be over represented in accessing primary care [Page 30].*
- *In Kent there were a total of 2,448 NHS admissions related to personality disorder, between 2012-13 and 2014-15, in persons aged 16-74 years.*
- *Using data from the 2007 Adult Psychiatric Morbidity Household Survey in England,*[16] *borderline personality (or emotionally unstable personality disorder) is the most*

prevalent sub type and is estimated nationally at 0.5-0.8% of the population aged 16-74 years. In Kent borderline personality disorder is the most common personality disorder diagnosis with 58% of all personality disorder admissions in Kent over 3 years in 16-74 year olds.

- *Significant numbers of PD patients self harm, and have harmful drug and alcohol behaviours. This underlines the challenge of dual diagnosis and the need for shared pathways and protocols such as have been agreed in Kent.*

Gender

- *Splitting the admissions by gender in Kent, women are 2.7 times more likely to be diagnosed with a personality disorder than men.*
- *Data provided for this needs assessment shows 80% of all inpatient borderline personality disorder cases in Kent are women.*
- *The second most common personality diagnosis is "personality disorder, unspecified", which reflects that personality disorders can be challenging to diagnose; the gender ratio follows the same female/male proportions seen in borderline personality disorder.*
- *Antisocial personality disorder or dissocial personality disorder (ASPD) shows a male dominant proportion of admissions nationally. National prevalence is 1% in men and 0.2% in women[17]. Kent has a similar male dominance of those diagnosed with ASPD: 90% are male, 10% female.*

Age

- *The admission age profile in Kent follows that of England with younger people aged 18 to 34 admitted in greater numbers than older people.*

1.3 Key Recommendations

- *There is a clear pattern of more PD admissions rom Kent's more deprived communities and greater risk for children of developing of conduct disorder; a review by KCC commissioners of preventative services and service pathways for families with children at risk of or presenting with conduct disorder is needed.*
- *An audit is needed to establish equity of access to PD services across Kent by groups identified in the Equality Act 2010 and other vulnerable groups.*
- *People with personality disorders can display challenging behaviours and tend to present in crises in various health and social care settings, making continuity of care difficult. NHS commissioners in Kent need to work with providers to develop and commission services with care pathways better able to respond to and support people with personality disorder.*
- *Between 50% and 78% of adult prisoners are believed to meet criteria for one or more personality disorders, and even higher prevalence estimates have been reported among young offenders.[18] Greater understanding of the support pathways to and from prison in*

Kent for people with personality disorder is required through closer working with NHS England and CCG commissioners.

- *The NHS Parity of Esteem [19] policy needs greater profile as it seeks to ensure the physical health needs of people with a serious mental illness are met in order to improve their quality of life and life expectancy; life expectancy for those with personality disorder, as with other serious mental illnesses, can be 20 years shorter than for the general population.*

1.4 Summary Call to Action: Early Action to Reduce Risk of Developing Childhood Conduct Disorder and Effective Interventions

It is vital to identify children in their early years at risk of developing conduct problems and to ensure pathways exist that enable children to receive the support they and their families and carers need using a robust assessment and referral system [20]

1.5 Summary of Recommendations by life course

Children and carers

- *Many people with personality disorder present with conduct and associated disorders in early childhood; ensuring adequate prevention, parental bonding, family support and transition services using a life course perspective is needed. Unsupportive and unstimulating parenting has been linked with some intellectual disabilities and conduct disorders.[21] More research needs to focus on preschool children's mental health in particular attachment in the early years. KCC and NHS commissioners should:*
    - *Review the availability of evidenced based interventions for children in their first two years of life in order to help prevent conduct problems later.*
    - *Review the availability across Kent of universal evidenced based parenting support programmes for parents of children 0-5, 5-10 and 10-16.*
    - *Ensure the opportunity to assess a child's development is being taken. These include ensuring opportunities for screening tests and developmental surveillance, for assessing growth, for discussing social and emotional development with parents and children, and for linking children to early years services are taken in a systematic way. This includes:*
        - *by the 12th week of pregnancy: identifying parental mental health problems at this stage decreases the risk of later parenting problems.*
        - *the neonatal examination.*
        - *the new baby review (around 14 days old).*

        - *the baby's 6-8 week examination.*
        - *by the time the child is one year old, and again at 2½ years old: Public Health England recommends an assessment of parental mental health problems and also parent infant bonding or attachment quality.*
    - *Review the availability of evidenced based interventions for children with conduct problems aged younger than 12 years and their families.*
    - *The needs of Children Looked After with conduct disorders should be understood.*[2223]

- *Kent County Council's (KCC's) Child and Adolescent Mental Health Services (CAMHS) Needs Assessment chapter notes there appears to be a lower proportion of 5 to 10 year olds within CAMHS services than would be expected. Commissioners should explore the proportion of children and their families accessing early help, including Troubled Families and substance misuse services in the most deprived electoral wards, to ensure the rate of early access is increased.*
- *CAMHS and adult health and social care professionals should work collaboratively to minimise any potential negative effect of transferring young people from CAMHS to adult services including:*
    - *Planning and managing the transition to adult services for young people with conduct and related disorders according to the best practice guidance described in the developing NICE Guidance.*[24]
    - *Referral of vulnerable young people with a history of conduct disorder or contact with youth offending schemes, or those who have been receiving interventions for conduct and related disorders, to appropriate adult services for continuing assessment and/ or treatment.*
    - *Timing the transfer to suit the young person, even if it takes place after they have reached the age of 18 years and continuing treatment in CAMHS beyond 18 years if there is a realistic possibility that this may avoid the need for referral to adult mental health services.*[25]
- *Support for parents should focus on identifying and supporting vulnerable parents, where appropriate antenatally, including:*
    - *parents with other mental health problems or with significant drug or alcohol problems.*
    - *mothers younger than 18 years, particularly those with a history of maltreatment in childhood.*

- *parents with a history of residential care.*
- *parents with significant previous or current contact with the criminal justice system.*
- *parents in a domestic abuse context.*

- *When identifying vulnerable parents, care should be taken **not** to intensify stigma associated with the intervention or appear to be labelling the problem as antisocial or problematic. This will increase the child's problems.*
- *For improved delivery of parent support, place emphasis on health promotion, prevention and early intervention, adopting the principle of progressive universalism (targeting more resources to those in greatest need) and advocate that screening, surveillance and other measures are implemented within the approach. In particular, it is important to ensure that screening is linked to appropriate support and intervention and is carried out in a supportive and sensitive manner to avoid a sense of parents being or feeling stigmatised, for example because of their own mental health problems.*[26]
- *Additional interventions targeted specifically at the parents of children with conduct problems (such as interventions for parental, marital or interpersonal problems) should not be provided routinely alongside parent training programmes, as they are unlikely to have an impact on the child's conduct problems.*

Adults

- *Services for people with personality disorder should offer continuity of care. They should be able to respond to the complex nature and variety of contacts those with personality disorder have with services across the public sector as part of a holistic approach.*
- *Greater knowledge of personality disorders and skills to support people with personality disorder to manage the associated risks to their health is needed in Kent. Knowledge and skills development should be reviewed in suicide prevention plans and dual diagnosis services alongside primary and secondary care services and voluntary sector support.*
- *People with PD present in a fragmented way across public services, prison healthcare and the offender 'pathway' including drug and alcohol services, making continuity of care a challenge. Commissioners and providers of child and adult mental health services should work together in order to establish a more responsive model of support that offers continuity of care for this challenged community.*
- *Taking into account the complexity of need, clinical commissioning groups (CCGs) should review pathways and explore how to improve access and continuity to support PD patient services across Kent.*

- *The commissioners need to understand better the pathways for the high numbers of PD specific non elective admissions in East Kent Hospitals and Maidstone and Tunbridge Wells Trusts and to explore if interventions earlier on the pathway can reduce numbers of non-elective admissions.*
- *NICE Borderline PD guidance suggests that studies of BPD in the community have found BPD is equally prevalent in both genders. Therefore commissioners need to review why there is a smaller prevalence for men in Secondary Uses Service (SUS) data.*
- *The percentage of admissions for the 15-29 age group is reducing. Commissioners should monitor this trend and ensure interventions for young people continue to support a reduction in admissions.*
- *Eleven individuals in Kent have had between 11 and 41 admissions over a three year period. This is a significant number of people for whom the current model of support may need to be reviewed as a priority (Table 9).*

2. Aims, Objectives and Personality Disorders Explained

2.1 What this Needs Assessment will cover.

Personality disorders are longstanding, ingrained distortions of personality that interfere with the ability to make and sustain relationships.[27] This makes providing support for people with personality disorder a challenge. Those with personality disorder display challenging behaviours, are high users of primary and secondary health care services, as well as other support services, and are high users of the health, social care, and criminal justice system [28] when compared with the general population.

In a British Psychological Society report, personality disorders were described as extreme variants of normal personality that are associated with significant dysfunction or distress; they are associated with wide ranging adverse consequences, such as suicide, self harm, addiction, family breakdown and social exclusion.[29]

This needs assessment will give an overview of the definitions, prevalence, and classifications of the key types, causes, risks associated with personality disorder and local services and interventions for the prevention and support of personality disorder.

This needs assessment does not include significant data or recommendations on personality disorder in prisons which is the subject of a separate needs assessment led by NHS England in the South East; personality disorder is a significant factor in prison and in criminal justice processes.[30]

Parity of Esteem: the importance of Physical Health Inequality

Physical health is a major concern for people with mental health problems, who are depressed or who have a more serious behavioural condition like PD. They face discrimination, stigma and poorer physical health outcomes. People with a mental illness have poorer access to routine services and on average die 15-20 years earlier.[31] This needs assessment will not report on the physical health of people with personality disorders; a further audit will be undertaken to establish if people with serious mental illnesses have access to physical health care.

2.2 The Aim of this Needs Assessment

This Personality Disorder Needs Assessment aims to gather epidemiological and diagnostic information to understand the prevalence of personality disorder (PD). It develops a conceptual framework for the key determinants of PD,[32] including biological, epidemiological, sociocultural, and economic determinants. It seeks to identify evidence for intervention and prevention strategies. It suggests priorities for strategies and recommends priorities to support commissioners, providers and communities in their work to reduce the risks of people developing PD and in their support for people living with PD.

2.3 Objectives of this Needs Assessment

The objectives of the PD Needs Assessment are:

Intelligence: this needs assessment provides a baseline of the current picture of PD

- nationally, internationally and in
- Kent

The needs assessment will contribute to:

Planning: to help decide what **preventative interventions** and **services** are required, at what age (for example the prevention of PD needs to start at a very early age), for how many people, what the effectiveness of these services will be, what benefits will be expected, and at what cost.

Efficiency: having assessed needs, commissioners can measure whether or not PD resources have been appropriately directed i.e. do those who need a service get it? What are the pathways and processes across service providers? Can these be used to measure the impact of interventions and support service development?

Equity: reduction in health inequalities associated with PD through prevention and early identification and the improvement of the spatial allocation of resources between and within different groups.

Involvement of stakeholders: exploration of this PD Needs Assessment can stimulate the further involvement, ownership and engagement of various stakeholders in the process. It can support active engagement from all those affected by PD. Service users and the public gave their views to the mental health commissioners for Kent and Medway when they were engaged in the creation of the Live It Well in Kent (Mental Health) Strategy.[33] Their views are summarised as follows:

Local services should fit in with where we live:

- in the community as far as possible, rather than health locations.
- in places where everyone else also uses resources to get on with life.

They should be:

Personalised

- A single point of contact for service users, alternatives to medication , increased access to talking treatments, and better signposting to resources and services. Note: medication is not recommended specifically for the

treatment of PD but, because there are so many comorbidities, it may well be indicated for a person who has PD alongside other mental health (MH) symptoms.

Timely

- Services should be when we want them (which is usually early in life).
- There should be better out of hours support with 24 hour support for people in crisis.
- There should be proper procedure when police detain people with mental health problems.

Non stigmatising

- Service users should be empowered, not disempowered, by mental health services.
- Services should challenge stigma, not identify service users as separate from the rest of society.
- Services should support social relationships with people we know.

In addition a review of users of borderline PD self harm services provided by KMPT in June 2005 noted services should:

- not confuse self-harm with suicide
- help us look at life
- accept our view
- look at our relationships
- help us make decisions/choices
- relieve distress
- accept us
- help us see a future
- explore our feelings
- listen
- help find solutions
- keep us safe.

2.4 Methodology

This Joint Strategic Needs Assessment (JSNA) chapter provides a Kent wide needs assessment where data is available. It uses best evidence, national and international literature and local evidence to:

a) Review the literature and any additional relevant guidance.
b) Set out the expected number of Kent cases.

c) Set out current Kent cases based on available data.

d) Explore the key determinants of PD.

e) Identify the evidence for prevention and treatment, starting with identifying parents.

- f) Set out service provision and pathways.

This needs assessment has identified three areas which, taken together, provide a good body of evidence. These are:

- analysis of risk factors.
- expected prevalence of PD.
- service utilisation versus expected need.

This needs assessment will adopt a life course approach assessing the risks to vulnerable children, young people and adults to inform the prevention and management PD. There is a separate JSNA Chapter with the Children and Young People's Mental Health Needs Assessment available that should be read alongside this needs assessment.[34]

2.5 Data Sources and Analysis

Inpatient hospital activity data is sourced from hospital episode statistics (HES) produced by the Health and Social Care Information Centre and the Secondary Uses database (SUS data). It is analysed to extract data relating to hospital episodes of care for personality disorders. An admission (or spell) can be made up of a number of consultant episodes, with one consultant episode being the time a patient spends under the continuous care of a consultant. When care is transferred to a different consultant, the first episode finishes (finished consultant episode, FCE) and a second begins, making up a sequence of consultant episodes per spell or admission.

For the Kent data, we look at the first FCE within a spell which uses ICD-10 codes F60-F69 (disorders of adult personality and behaviour: see Table 1), as the primary diagnosis or in any of the subsequent diagnostic code positions. The data looks at hospital admissions and excludes Accident and Emergency (A&E) episodes.

Table 1: ICD-10 Code Definitions of Personality Disorder

ICD-10 code	Personality Disorder
F60.X	Specific personality disorders
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.2	Antisocial personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.8	Other specific personality disorders
F60.81	Narcissistic personality disorder
F60.89	Other specific personality disorders
F60.9	Disorder, unspecified
F61	Mixed and other personality disorders
F62	Enduring personality changes, not attributable to brain damage and disease of adult personality and behaviour
F63	Impulse disorders
F68	Other disorders of adult personality and behaviour
F69	Unspecified disorder

The Challenge of Data Quality

Where possible we have compared local data to national or regional data; where possible we break data down to local authority and CCG level for health and wellbeing boards.

Data quality for many aspects of this needs assessment is poor. For example, significant HES activity is classed as PD without a clear diagnosis beyond this statement. Improvements to data input and output are vital for commissioning and formal and expert diagnosis is essential.

It should also be noted that due to the different modelling approaches used within this needs assessment to demonstrate the various needs in Kent and the CCGs, overall numbers must be viewed with caution and discrepancies may exist. In this context the data and datasets set out and explored here are not the full picture of PD in Kent and its seven CCGs.

This issue was flagged in the context of KMPT recording diagnosis in accordance with Mental Health Payment By results; [35] KMPT clinical leads are aware the data has significant quality issues that need to be taken into account & exception reported. For example, in a recent survey (2016) only 109 of the 407 open referrals to specialist PD services in KMPT have a cluster 6 or 8 diagnosis which suggests that staff are not yet clustering accurately.

2.6 What is a Personality Disorder: Causes and Prevention

In mental health, the word personality defines the set of characteristics or traits that make each person an individual, including the ways we think, feel and behave.[36] PD has proven a difficult term to define but there is general agreement that the term refers to behaviours opposing commonly held expectations of what is "normal". This varies according to what is considered "normal" in different contexts.[37] The traits of PD behaviours are longstanding characteristics noticeable from childhood or early teens. These behaviours can make it hard to control feelings, can hinder coping strategies, make it difficult to sustain relationships, cause difficulty in interpreting social cues and can cause distress to the individual and/or to others.[38]

Over recent years, the World Health Organisation (WHO)[39] and the American Psychiatric Association[40] have both tried to provide a definitive definition of PD, and these are the two definitions most widely used by health professionals today:

- The WHO produced the "International Classification of Mental and Behavioural Disorders" definition (ICD-10) defining PD as: '*A severe disturbance in the character, logical condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption*'.

- Alternatively, the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) definition is based on personality traits, or "enduring patterns of perceiving, relating to, and thinking about the environment and oneself". It defines a PD as: *'An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'.*

To date researchers have not identified a qualitative distinction between normal personality functioning and PD[41] and, as such, both classification systems for personality disorder (ICD-10 and DSM-V) have little explanation of diagnosing presence versus absence of each personality disorder, so people do not fit neatly into just one given category. However, the American DSM-V guide to personality diagnosis recognises that certain patterns of personality "problems" seem to be shared by fairly large numbers of people. By identifying these patterns we can develop ways of helping that can be used wider than on an individual basis.[42] [43, 44]

BPD and ASPD were assessed in the 2007 Adult Psychiatric Morbidity Survey. There are a number of other personality disorders which are much less prevalent in Kent. All tend to be gathered into to three groups or clusters:

Cluster A: Odd/Eccentric/Suspicious

- Paranoid PD: pattern of distrust and suspiciousness such that motives of others are interpreted as malevolent (injustice).
- Schizoid PD: patterns of detachment from social relationships and restricted range of emotional expression (detached loners).
- Schizotypal PD: patterns of acute discomfort in close relationships, cognitive and perceptual distortion and eccentricities of behaviour (peculiarity).

Cluster B: Dramatic/Emotional Erratic/Impulsive

- Antisocial (Dissocial) PD: pattern of disregard for and violation of the rights of others.
- Borderline (Emotionally Unstable) PD: pattern of instability in interpersonal relationship, self-image and affects with poor impulse control.
- Histrionic PD: pattern of excessive emotionality and attention seeking (high drama).
- Narcissistic PD: pattern of grandiosity, need of admiration and lack of empathy.

Cluster C: Anxious/Fearful

- Avoidant PD: pattern of social inhibition, feelings of inadequacies, hypersensitivities to negative emotions (involvement is risky).
- Dependent PD: pattern of submissive and clingy behaviour related to an excessive need to be taken care of (limited sense of self).
- Obsessive compulsive (anankastic) PD: pattern of preoccupation with orderliness, perfectionism and control at expense of flexibility (order and structure).

Other specific personality disorders

Eccentric, immature, narcissistic, passive aggressive, psychoneurotic.

Personality disorders, unspecified

The three clusters of PDs are summarised in Table 2.

Table 2: DSM-IV Personality Disorders Grouped into Three Clusters [45]

Cluster A ***(odd / eccentric)***	**Cluster B** ***(dramatic / erratic)***	**Cluster C** ***(anxious / fearful)***
Paranoid *Distrusting and suspicious interpretation of others' motives.*	**Antisocial** *Disregard for and violation of the rights of others.*	**Avoidant** *Socially inhibited feelings of inadequacy, hypersensitivity to negative evaluation.*
Schizoid *Social detachment and restricted emotional expression.*	**Borderline** *Unstable relationships, self-image, affects, and impulsivity.*	**Dependent** *Submissive behaviour, need to be taken care of.*
Schizotypical *Social discomfort, cognitive distortions, behavioural eccentricities.*	**Histrionic** *Excessive emotionality and attention seeking.*	**Obsessive-compulsive** *Preoccupation with orderliness, perfectionism, and control.*
	Narcissistic *Grandiosity, need for admiration, lack of empathy.*	

Source: Alwin, N., Blackburn, R., Davidson, K. et al. (2006). Understanding personality disorder. Leicester

Antisocial and borderline personality disorders are both part of cluster B, emotional and impulsive. People with antisocial personality disorder (ASPD) are characterised by the presence of three or more of the following criteria from the age of 15 or earlier and with characteristics persisting into adulthood; therefore diagnosis is only possible for over 18s:

- Irresponsibility
- Deceitfulness
- Indifference to the welfare of others
- Recklessness
- A failure to plan ahead
- Irritability and aggressiveness

People with BPD are characterised by the presence of five or more of the following criteria (with diagnosis possible in childhood):

- Frantic efforts to avoid real or imagined abandonment
- Pattern of unstable and intense personal relationships
- Unstable self image
- Impulsivity in more than one way that is self damaging
- Suicidal or self harming behaviour
- Affective instability
- Chronic feelings of emptiness
- Anger
- Paranoid thoughts or severe dissociative symptoms (quasi psychotic)

The origin of individual categories is complex and constantly evolving. For example, it includes psychoanalysis (narcissistic, borderline personality disorder), empirical longitudinal research (antisocial personality disorder), clinical observations by influential early 20th century German clinicians (dependent, obsessive compulsive, paranoid disorders) and this can be obscured by subsequent changes of clinical opinion, new research and negotiations which precede new editions of the glossaries.[46, 47]

Statistical analyses of the categories show that there are three or four higher order factors or groups,[48] suggesting that there may be too many categories. In addition we know there are issues with reliable diagnosis and many people accessing mental health services meet criteria for at least two, often four or more.[49] In addition, in the last few years the study of personality traits such as the "Five Factor Model": Openness, Conscientiousness, Extroversion, Agreeability, and Neuroticism has gained momentum and will be central to any redesign of services in the light of this needs assessment. [50, 51]

Both the current editions of the major classificatory systems, the International Classification of Diseases, 10th revision,[52, 53] include ASPD as a diagnosis, although ICD-10 describes ASPD as dissocial personality disorder.[54] Both terms have been used in England in the literature. Data in this needs assessment is presented using the ICD-10 classification of "dissocial". Under current diagnostic systems, ASPD is not formally diagnosed before the age of 18 but the features of the disorder can manifest earlier as conduct disorder.

Emotionally Unstable Personality Disorder (Borderline) Personality Disorder (BPD)

NICE notes the term "borderline personality" was first proposed in 1938 the United States for a group of patients who "fit frankly neither into the psychotic nor into the

psychoneurotic group". Borderline personality disorder (BPD) is most common in adulthood and is present in just under 1% of the population. BPD is the most common diagnosis of PD in Kent and is characterized by mood instability, volatile relationships, and unstable self-image and impulsiveness, and is sometimes referred to as a disorder of emotional regulation. [55, 56, 57]

International studies show that 9% to 22% of people receiving psychiatric outpatient treatment have BPD, and in some settings over 40% of inpatients.[58] People with BPD sometimes experience patterns of rapid fluctuation between confidence and despair, often accompanied by fear of abandonment and rejection, severe difficulties with sustaining relationships, and suicidal thinking. These behaviours mean that people with BPD are at particular risk of self-harm, parasuicide and completed suicide.[59] 60 to 70% of BPD patients attempting, and 8 to 10% completing, suicide. [60]

The nature of their condition means that services can find this client group very demanding; this leads to the type of observation shared below:

Pejorative terms such as "difficult," "treatment resistant," "manipulative," "demanding" and "attention seeking" are often used, and may become a self-fulfilling prophecy as the clinician's negative response triggers further self-destructive behaviour.

BPD is generally the most prevalent category of PD in non forensic mental healthcare settings. As noted earlier there is an expected prevalence of 50/50 BPD by gender. NICE has observed that the majority of people diagnosed with PD, most of whom will have BPD, will be women and this is the experience in Kent where 73% of admissions for BPD are women; this presents us with a problem of gender inequity in access to services.

Guidance for the recognition, treatment and management of BPD were reviewed by NICE in January 2015.[61] It notes that the presence of affective and anxiety disorders, psychosis, or substance use disorder, or the occurrence of an acute medical or surgical condition can all mimic symptoms of BPD; to ensure clinical quality a primary diagnosis of BPD should only be made in the absence of mental or physical illness.

Antisocial Personality Disorder

NICE describes Antisocial Personality Disorder (ASPD) as characterised by disregard for and violation of the rights of others. People with ASPD exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others. The condition is associated with a wide range of interpersonal and social disturbance.[62]

People with ASPD have often grown up in families in which parental conflict is typical and parenting is harsh and inconsistent.[63] As a result of poor parenting and/or the child's difficult behaviour, the child's care is often interrupted and transferred to agencies outside the family. This in turn often leads to truancy, having delinquent associates and substance misuse, which frequently result in increased rates of unemployment, poor and unstable housing situations, and inconsistency in relationships in adulthood. The importance of supporting children is explored further in section 4.2.2.

Many people with ASPD have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour. This is in addition to the issue in healthcare around Parity of Esteem which leads to a failure to attend to the physical health of people with PD.[64] People with ASPD have a pattern of aggressive and irresponsible behaviour which emerges in childhood or early adolescence. They account for a disproportionately large proportion of crime and violence committed. [65]

In Kent 90% of people diagnosed with ASPD are male and only 10% female. Similar patterns of majority male proportions are seen for mixed PD, paranoid PD and anxious PD. Not all people with ASPD are offenders but the condition is characterised by a wide range of antisocial behaviours. However, evidence for the treatment of these behaviours outside the criminal justice system is extremely limited.[66] Understanding the engagement pathway better for people would help commissioners and service providers improve these services.

2.7 The development of personality disorder

According to the British Psychological Association,[67] a combination of biological, social and psychological factors are associated with the development of PD and they argue it is difficult to show whether one of these is more predominant than the others. For example:

- Biological factors could include genetic, temperament or biochemical factors.
- Psychological factors could include childhood neglect, childhood abuse, post-traumatic stress disorder or family relationships. New theories led by Lineham around the biosocial model of personality disoder and invalidation are very important in this regard.[68]
- Social factors could relate to culture, peer groups, socioeconomic disadvantage or gender related childhood maltreatment.

On the Mental Health Foundation website[69] and on the Personality Disorder Information site,[70] the British Psychological Association concludes that:

"… It is apparent that no single factor within an individual's environment, even in combination with a biological vulnerability, would be likely to produce a significant level of personality disorder. Therefore, multiple adverse life experiences are likely to be necessary."[71]

As with PD generally, the cause of BPD is unclear but evidence indicates that there are likely to be several contributory factors as opposed to a single cause. Research on the possible causes and risk factors for personality disorders is still at a very early stage. Scientists generally agree, however, that genetic and environmental factors are likely to be involved. Studies on twins with BPD suggest that the illness is also strongly inherited.[72] Another study shows that a person can inherit his or her temperament and specific personality traits, particularly impulsiveness and aggression. Scientists are studying genes that help regulate emotions and impulse control for possible links to the disorder.[73] There is increasing understanding that a child's environment and positive parenting free from risk factors such as violence, and sexual abuse act to recuce the risk of conduct disorders or help with recovery with appropriate support. In 4.1 we explore the impact of adverse childhood experiences including domestic violence, parental drug and alcohol misuse (the "toxic trio") and the links to inequality.

2.8 Adverse Circumstances and Inequality

People can be predisposed to BPD and ASPD traits through both environmental and genetic factors and many report a history of abuse, neglect or separation in childhood. The infants shown to be at risk of developing PD in later life are those that have been subjected to unpredictable and prolonged separation from their maternal figure during the separation-individuation process of development that occurs around age 18-36 months. The pathogenesis of borderline personality is complex and probably multifactorial, as in the validation theories put forward by Linehan, which state that borderline pathology results from the interaction of a biologic emotional vulnerability and a pervasively invalidating environment.[74] [75]

Research also suggests that a series of events are likely to trigger the onset of the disorder in early adulthood and that people with BPD are more likely to have been victims of violence, including rape, due both to impulsivity as well as being in a harmful environment which may lead to poor judgement in choosing partners and lifestyles.[76]

Mary Boyle and colleagues note:

"There is strong evidence that emotional distress and behavioural problems, even the most bizarre, are understandable responses to or ways of actively trying to manage adverse circumstances and relationships".[77]

These observations are important when considering the causes and therefore prevention of personality disorders. Wilkinson notes:

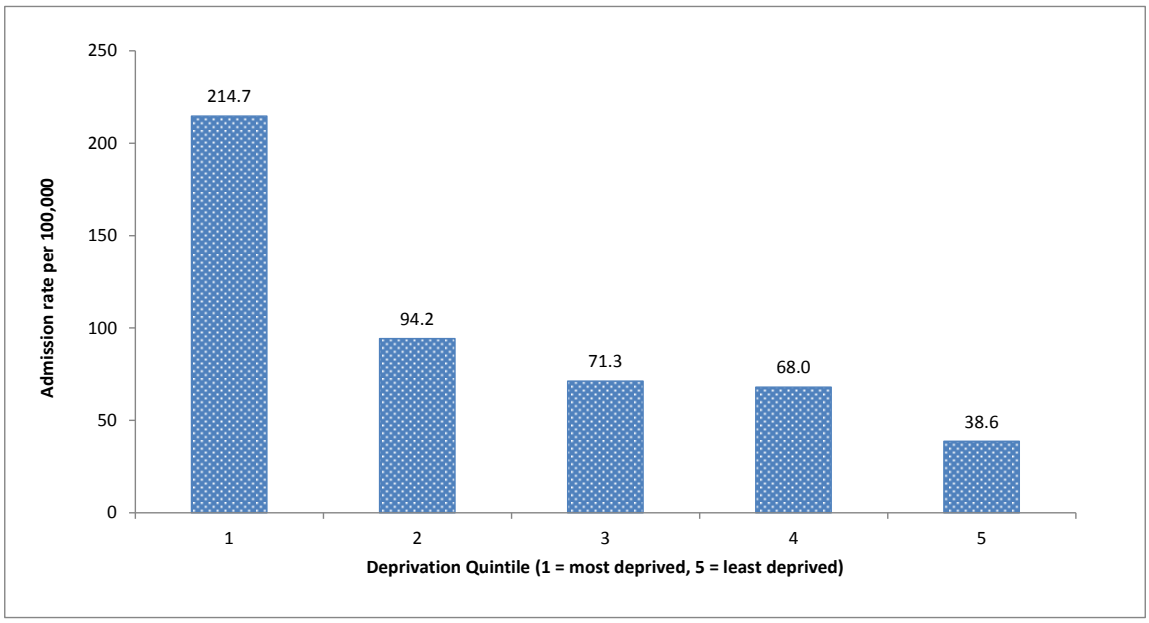
"presenting adverse environments and relationships largely as consequences of 'having a mental disorder' rather than as antecedents of a range of meaningful and purposive - if problematic - responses to adversity. By inserting an unspecified innate vulnerability

between the person and their family or wider environment, the claimed vulnerability and not the environment becomes the focus of concern."[78]

International studies show that episodes of severe mental illness are also strongly correlated with inequality in society more broadly, such as income inequity.[79] Research on problems with social gradients find that more unequal societies also have lower levels of trust and social capital, poorer physical health, higher rates of obesity and teenage pregnancies and births, low child wellbeing, educational achievement and social mobility, and higher levels of violence and imprisonment.[80]

Conduct disorders, and associated antisocial behaviour, are the most common mental and behavioural problems in children and young people. The Office of National Statistics (ONS) surveys of 1999 and 2004 reported that conduct disoder prevalence was 5% among children and young people aged between 5 and 16 years. Conduct disorders nearly always have a significant impact on functioning and quality of life. The 1999 ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three to fourfold increase in prevalence in social classes D and E compared with social class A. [81]

Figure 1: Hospital Admission Rate for PD in Kent by Index of Multiple Deprivation Quintile, 2014-15.[82], [83]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)
Department for Communities and Local Government indices of Deprivation 2015

Figure 1 shows a disparity in admission rates for PD between the most deprived and least deprived quintiles. Research on problems with social gradients finds that more unequal societies have lower levels of trust and social capital, poorer physical health, higher rates of obesity and teenage pregnancies and births, low child wellbeing, educational achievement and social mobility, and higher levels of violence and imprisonment.[84]

Health inequality causes real suffering and taking into account the rates of hospital admission by deprivation quintile and the literature on causes of PD, the evidence is clear that facing deprivation in childhood contributes to the development of personality disorders. Policies and action in Kent to build resilience in communities, support families and address inequality in a structural, as well as individual, context are still needed.

Asset based approaches and other community capacity building programmes are part of the solution and are gaining traction internationally, nationally[85, 86] and in Kent.[87] Asset based approaches include ABCD (Asset Based Community Development) a methodology that seeks to discover the strengths within communities as a sustainable means to keep people well, connected and contributing to their community. This approach is often promoted in the context of community development and growing community "resilience".[88] By addressing inequalities it can countribute on KCC's Mind the Gap challenge[89] which seeks to direct energy and partnership resources to those communities at greater risk of serious mental illness such as personality disorder.

Communities that exist in areas of greater deprivation need the tools (both collective and individual) to cope with stresses and life events.[90] This links to the health service mantra "make every contact count", and asset based community development (ABCD) approaches supported by KCC , in partnership with CCGs and local authorities across Kent. More should be done to combat stigma facing people with PD as part of building a more equal society.

In summary, there is a link between adverse environments, inequalities and the development of PD. Health inequalities and mental health are linked, children and adults living in deprived areas are likely to experience more life events and stresses which can be hard to cope with. These appear to increase the risk of conduct disorders in children and PD in adults, and lead to higher rates of hospitalisation.

2.9 The Risks Associated with Adult Personality Disorders

Analysis of psychiatric case registers and mortality data suggests that for men and women with PD life expectancy is significantly shorter than for the general population (18.7 years shorter and 17.7 years shorter respectively), with the highest mortality rates amongst younger age groups.[91] Closing the mortality gap is a challenge identified in the Parity of Esteem Campaign.

Limited data suggest that BPD occurs in up to 22% of adolescents and young adults receiving outpatient treatment.[92, 93] BPD in young people demarcates a group with high morbidity and a particularly poor outcome. This disorder uniquely and independently predicts current psychopathology, general functioning, peer relationships, self-care and family and relationship functioning.[94] It also uniquely predicts poor outcomes up to two decades into the future, increased risk of mental health problems such as depression, posttraumatic stress disorder, anxiety disorders, bipolar disorders, and impulse control disorders such as

deficit hyperactivity disorder (especially substance use and mood disorders)[95] as well as interpersonal problems, distress and reduced quality of life.[96, 97]

BPD is particularly associated with drug or alcohol dependence. Within this cohort there tends to be more men than women with BPD. An estimated 35% to 55% of those with substance misuse issues have symptoms of a BPD,[98] and PD is significant amongst those with an eating disorder, those within the criminal justice system[99] and those presenting with chronic self harm.[100]

As a result of the higher frequency of self harm amongst people with BPD, there is a recognised increased risk of suicide, with 60% to 70% attempting suicide at some point in their life, and estimated suicide completion in approximately 10%.[101] Suicide is one of the most tragic outcomes of any mental illness and those in contact with mental health services are a key priority for the Kent and Medway Suicide Prevention Strategy.[102]

Unlike suicide attempts, self harming behaviours often do not stem from a desire to die. However, some self harming behaviours may be life threatening. Self harming behaviours linked with BPD include cutting, burning, hitting, head banging, hair pulling, and other harmful acts. People with BPD may self harm to help regulate their emotions, to punish themselves, or to express their pain; they do not always see these behaviours as harmful.

3. Population Data

3.1 Prevalence of Personality Disorder

An analysis of participants in the British National Survey of Psychiatric Morbidity (2000), aged 16-74 years living in private households in England, Scotland or Wales[103] concluded that the weighted prevalence for any PD is 4.4% (C.I 2.9%-6.7%). For PD unspecified (where the individual fulfils 10 or more PD criteria but no diagnosis) the prevalence is 5.7% (C.I. 3.8%-7.6%).

Using this estimated prevalence for PD in the population, Table 3 shows the mid 2014 estimated population of Great Britain, England, the South East region and Kent. It suggests that within Kent there are 66,458 people with a PD, or 86,092 people with an unspecified PD (those who meet 10 or more of the personality disorder criteria, but not the diagnosis of any specific disorder).

Table 3: Estimated Numbers of Personality Disorder in Kent, South East, England and UK from the applied National Prevalence rates[104]

	Mid-2014 Estimated Population	Estimated Prevalence of Personality Disorder (4.4%)	Estimated Prevalence of Unspecified personality disorder (5.7%)
UK	64,596,800	2,842,259	3,682,018
England	54,316,600	2,389,930	3,096,046
South East	8,873,800	390,447	505,807
Kent	1,510,400	66,458	86,092

Source: Adapted from: Coid et al. 2006 – Prevalence and correlates of personality disorder in Great Britain

Understanding PD prevalence is a challenge. The Psychiatric Morbidity Survey (PMS) measured personality disorders in the UK.[105] They reported that the weighted prevalence of 4.4% was substantially less than most other studies. This suggests that between 5% and 13% of the population have diagnosable personality disorder,[106] with approximately 4%, some two and a half million people, who could benefit from professional help.[107] The authors also reported higher prevalence rates for older respondents, which is in contrast to other studies.

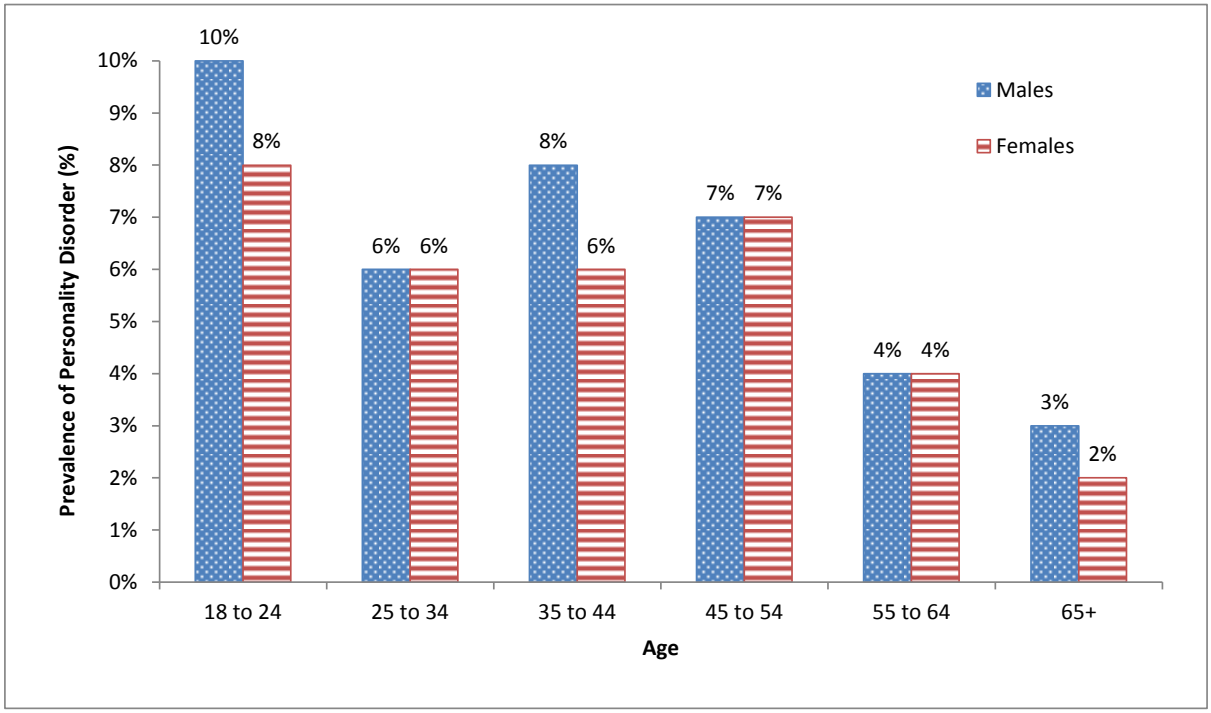
Table 4: Predicted Numbers in Kent from Contrasting Prevalence Estimates

Psych Morbidity 4%	Other study? Lower 5%/ upper 13%	Australian Study 5.8%
66,458	Lower 86092	
	Upper 196,352	

The King's Fund, in a more recent study on the economic impact of PD, concluded that the most suitable prevalence data were from an Australian survey (see Figure 2)[108], which produced prevalence figures for different age bands with the findings being consistent with those from other studies.[109] These were based on a community sample of more than 10,000 people which included older adults. These rates decrease with age as reported elsewhere. The overall prevalence rate in England when these age specific rates are applied is 5.8% which is reasonably consistent with the Department of Health analysis of 5.7%. So we might reasonably assume 5.7% and the age estimates too.[110]

When applied to Kent population this will predict that there is a high prevalence in younger men and women and males aged 35-44, decreasing with age.

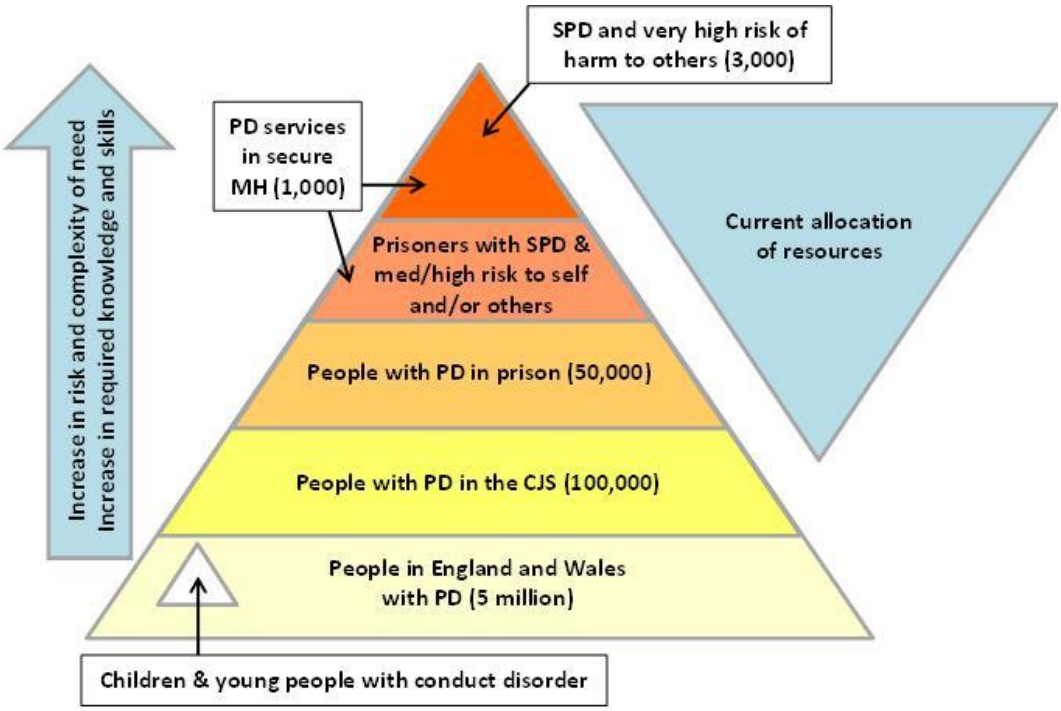
Figure 2: Prevalence of Personality Disorder in Australia by Age and Gender[111]



Source: Andrews G, Hall W, Teeson M, Henderson S (1999). The Mental Health of Australians. Canberra: Commonwealth Department of Health and Aged

Figure 3 below shows the range and scale of PD in England and Wales. This definition includes 5 million people in England and Wales who have some form of diagnosable PD, and approximately two and a half million people with diagnosable PD who would benefit from help.

Figure 3: Range and Scale of Personality Disorder in England and Wales[112]



Source: Department of Health, 2016

Data on Borderline Personality Disorder

Data taken from Adult Psychiatric Morbidity Survey in England Survey 2007

The DSM-V (Diagnostic and Statistical Manual of Mental Disorder) defines BPD as: "*A pervasive pattern of instability of interpersonal relationships, self-image, and affects mood and marked impulsivity beginning by early adulthood and present in a variety of contexts*"[113]

Table 5: Prevalence (%) of Borderline Personality Disorder in England by Age Group and Gender, 2007.[114]

	Age Group			
	16-34	**35-54**	**55-74**	**Total 16-74**
Males	0.3	0.2	0.4	0.3
Females	1.4	0.5	-	0.7
All People	0.8	0.4	0.2	0.5

Source: Table adapted from Adult psychiatric morbidity in England survey, 2007

Table 6: Expected Number of BPD Cases in Adults Aged 16-74 in Kent, Based on Mid-Year Population Estimates 2010 to 2014

	Year				
	2010	**2011**	**2012**	**2013**	**2014**
Whole Kent Population	1046959	1057045	1065904	1075427	1087619
Expected Number of BPD (based on UK prevalence of 5 per 1,000)	5235	5285	5330	5377	5438

Source: Table adapted from Adult psychiatric morbidity in England survey, 2007

Office for National Statistics Mid-Year Resident Population Estimates

Table 7: Expected Number of BPD Cases In Adults Aged 16-74 in Kent by Age Group and Gender, 2014

	Age Group			
	16-34	**35-54**	**55-74**	**Total 16-74**
Males	515	400	658	1608
Females	2406	1031		3861
All People	2749	1624	658	5438

Source: Adult psychiatric morbidity in England survey, 2007 Office for National Statistics Mid-Year Resident Population Estimates

The age group that shows the highest prevalence of BPD in females is 16-34 years, whereas in males, ages 55-74 have the highest prevalence.

3.2 National Estimates of People Accessing Primary Care with PD

Research in 2000 suggests that among people accessing primary care, the prevalence of PD is 24%.[115] PD will have a greater representation in primary care. The King's Fund research from 2008 argues that we do not know how likely people with PD are to visit their GP and there may be reasons for it being both higher and lower than national norms.[116] Personal Medical Services data shows that 64.6% of all people have consulted their GP for some reason in the previous year. The Kings Fund has assumed that people with PD have the same rate of use. (In actual fact the use of GP services could be more or less than average, but

definitive data were unavailable.) This suggests that, nationally, 1.59 million people with PD are in contact with their GP.

3.3 National Estimates of People with PD Accessing Community Mental Health Teams

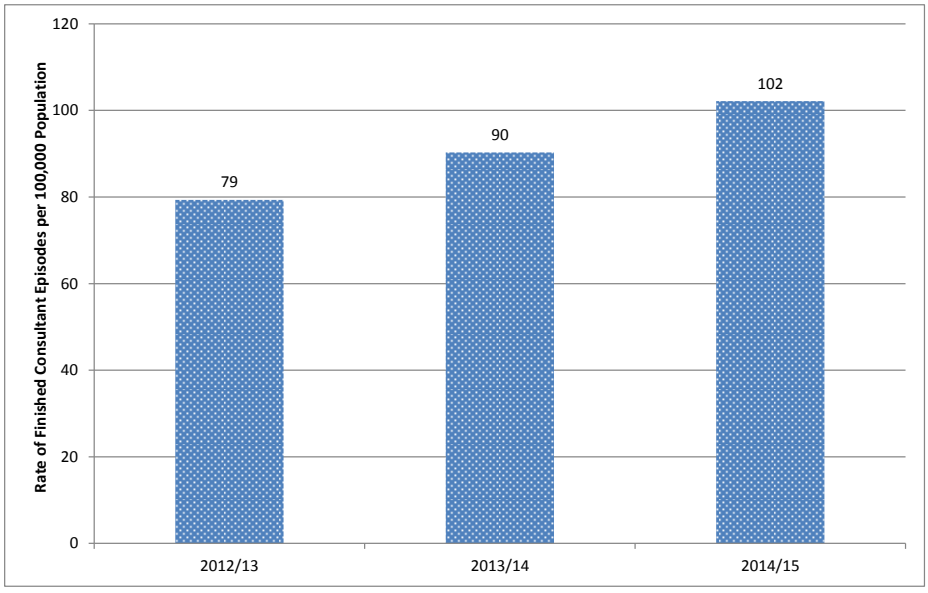
A National study in 2010 found that up to 40% of Community Mental Health Teams' time is spent supporting people with PD.[117]

3.4 Demand: Hospital Admissions for PD in England

It is important to evaluate the number of hospital admissions relating to PD, to determine the impact this is having on NHS services and to understand the relationship between activity and prevalence. In England, over the last three years, between 2012-13 and 2014-15, there has been a steady increase in hospital admissions in which a diagnosis of PD is recorded. For each episode a diagnosis is given to record the reason for care as either the primary diagnosis (the main reason for the episode of care) or up to 19 secondary diagnoses, believed to be related comorbidities.

When looking at all PD diagnoses (primary and secondary), Figure 4 shows finished consultant episodes (FCEs) per 100,000 population. In 2014-2015 there was a rate of 102 FCEs per 100,000 population, an increase of 28.75% since 2012-2013.

Figure 4: Rate of PD Related (All Diagnosis Fields) Finished Consultant Episodes for People All Ages, England 2012-2013 to 2014-2015[118]

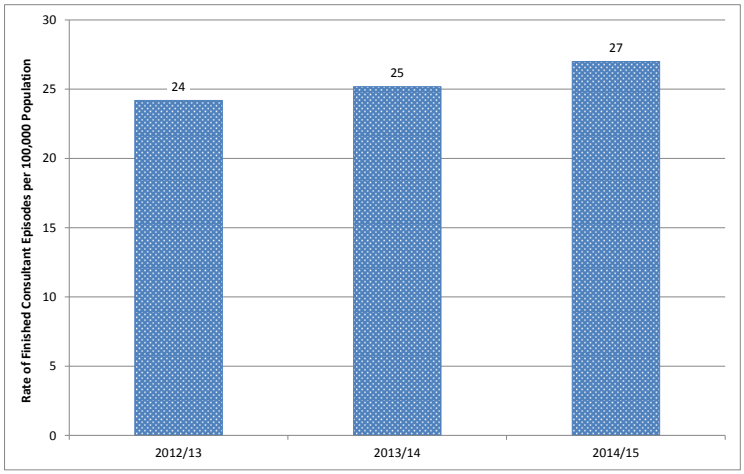


Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

Figure 5 shows the trend in episodes for which the primary diagnosis is PD, i.e. where PD was the main reason for the patient receiving care. It demonstrates there was a rate of 27

FCEs with a primary diagnosis of PD per 100,000 population in 2014/2015, up from 24 in 2012-13. This is an increase of 11.6%

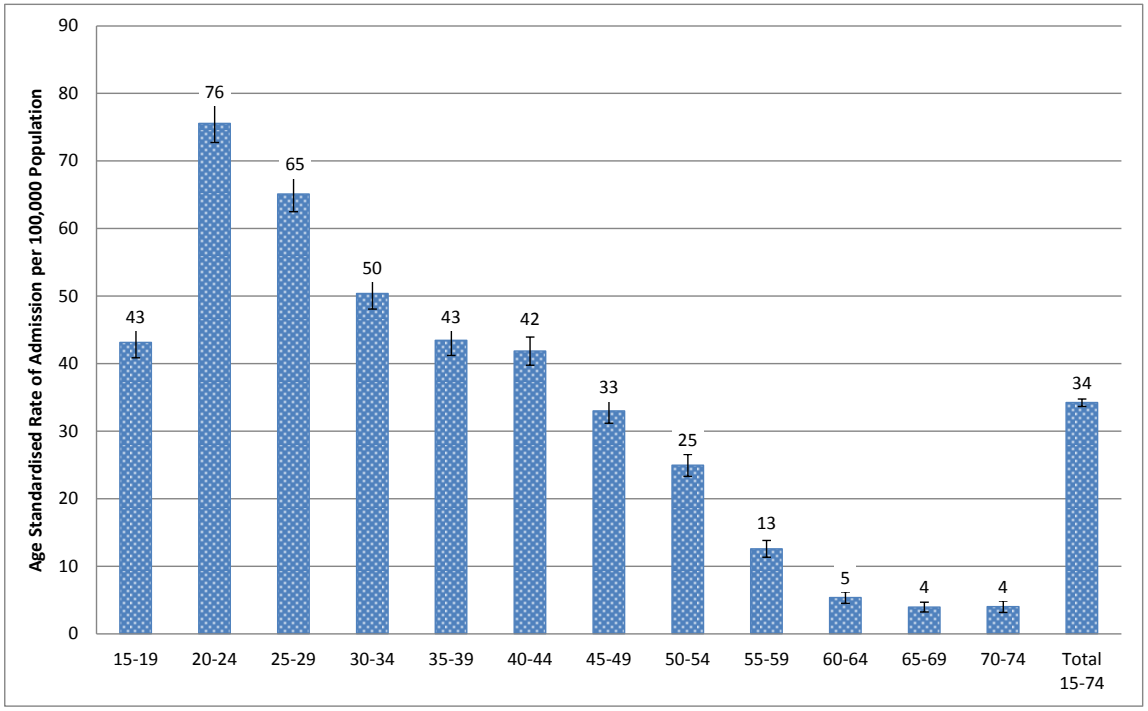
Figure 5: Rate of PD (Primary Diagnosis) Finished Consultant Episodes for People All Ages, England 2012-2013 to 2014-2015



Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

In England as a whole, as set out in Figures 4 and 5, there has been an increase in PD related admissions, both for admission where PD is the main diagnosis and for admissions where it is considered to be a relevant co-morbidity. It would appear that admissions with PD as a comorbidity are increasing at a faster rate than when this disorder is the main reason for admission.

Figure 6: Age Standardised Rate of PD (Primary Diagnosis) Admissions for People Aged 15 to 75, England, 2015[119]



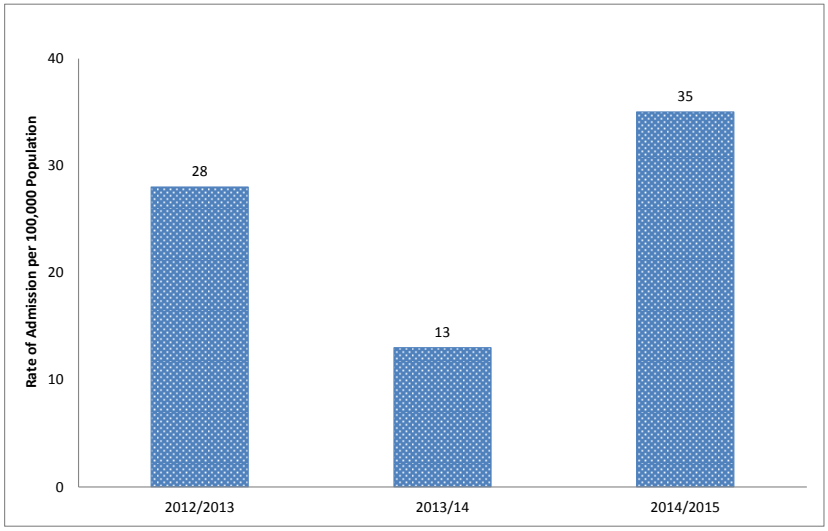
Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

Figure 6 shows in England the highest rate of admissions for PD as a primary diagnosis are amongst young people aged 20-29.

3.5 Demand: Hospital Admissions for PD in Kent

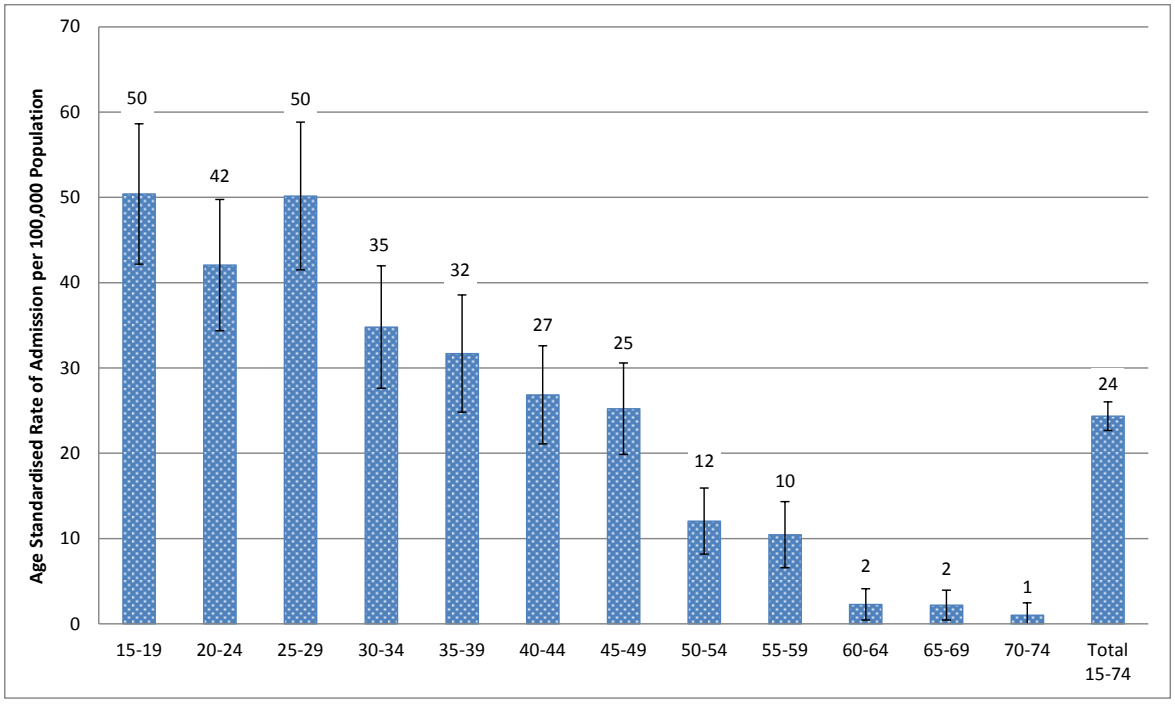
In Kent, the trend for admissions with primary diagnosis for PD is increasing (Figure 7).

Figure 7: Age Standardised Rate of PD (Primary Diagnosis) Admissions for People All Ages, Kent, 2015[120]



Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

Figure 8: Three-Year Average Age Standardised Rate of PD (Primary Diagnosis) Admissions for People Aged 15-74, Kent, 2012-2015[121]

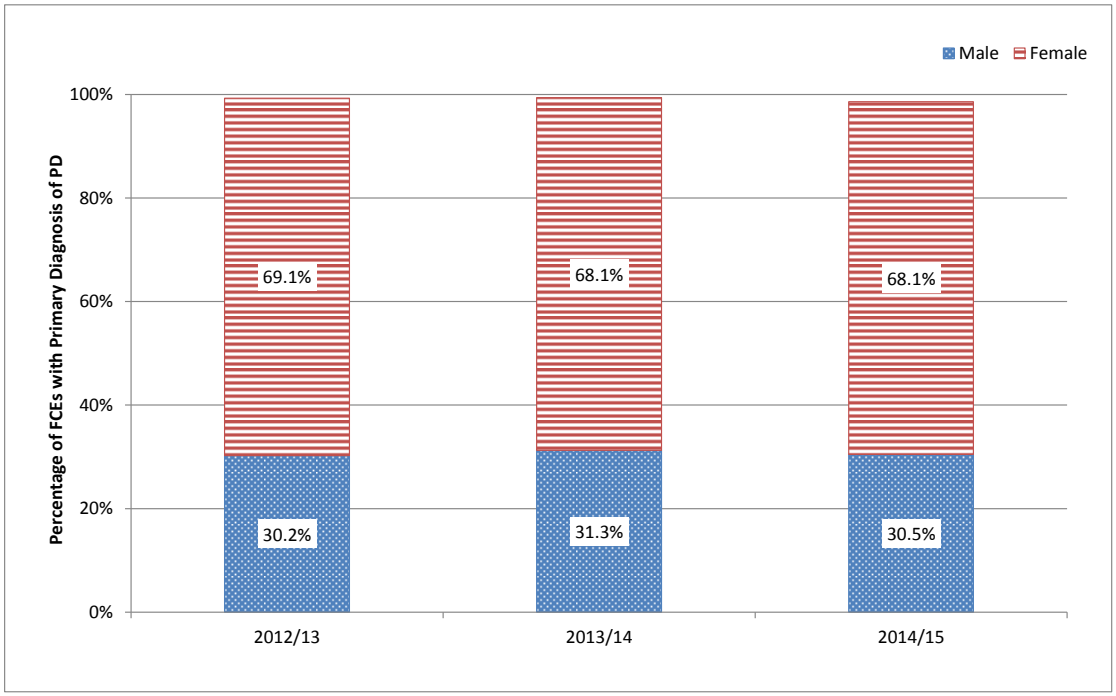


Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

Figure 8 shows the three year rate of admission in Kent; the age profile follows that of England, with younger people admitted in greater numbers than older people.

Admissions by Gender

Figure 9: Proportion of PD (Primary Diagnosis) Finished Consultant Episodes for People All Ages by Gender, England 2012/2013 to 2014/2015[122]

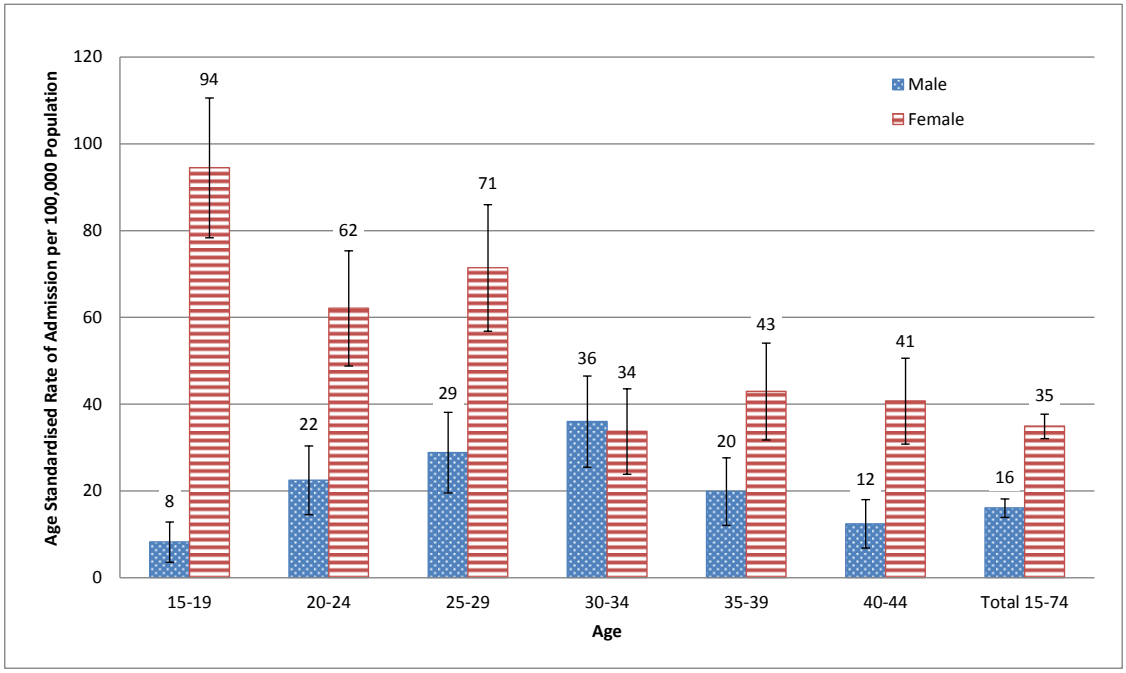


Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

Figure 9 shows that in England between 2012-13 and 2014-15, at least two thirds of all FCEs were for females admitted to hospital. This is in line with national trends for borderline personality disorder, which is the primary diagnosis in the majority of FCEs (see Figure 11). This female dominant split is also seen for unspecified PD. NICE Guidance on BPD notes that in community samples the prevalence of the disorder is roughly equal male to female,[123] whereas in acute settings and services women are more likely to seek treatment.

This poses an important problem of where the largely male "missing" population is and how they are diagnosed, if at all, and where they are accessing support possibly in the criminal justice system.

Figure 10: Three-Year Average Age Standardised Rate of PD (Primary Diagnosis) Admissions for People Aged 15-44 by Gender, Kent, 2012-2015[124]

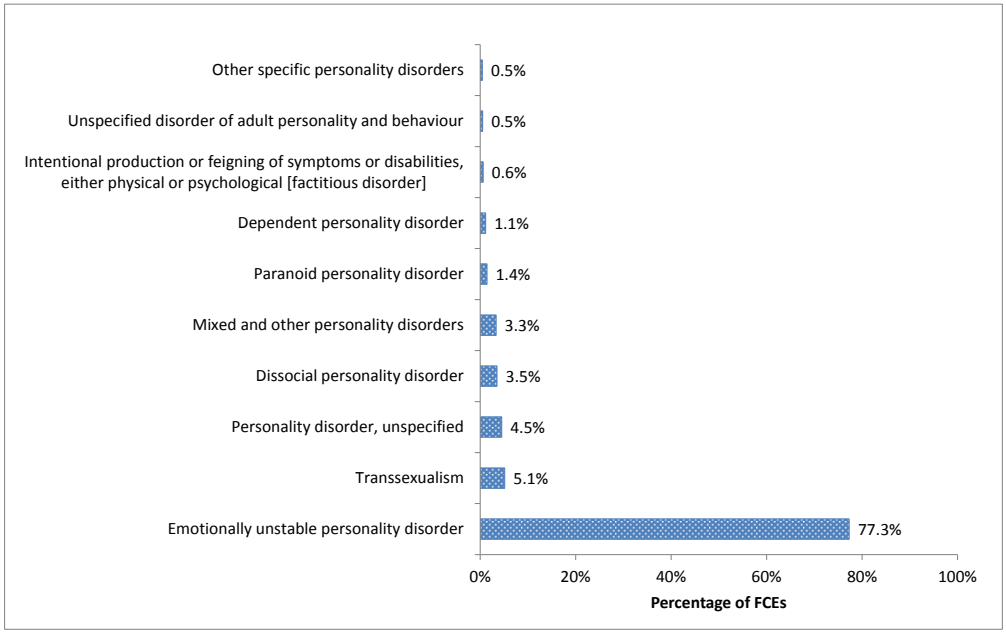


Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

Figure 10 shows a marked difference in the rate of admissions by gender for diagnosis of PD in Kent. Women form a significant majority of admissions. This reflects the gender difference in the diagnosis of BPD. When split into gender, Kent's PD related hospital admissions show 73% are females and 27% males. This pattern is also seen with BPD; although an even greater proportion, for inpatient activity where 80% diagnosed with BPD are female, compared to 20% males.

More research is needed to establish if some of the "missing males" in Kent are presenting in Kent's substance misuse services potentially misusing drugs and alcohol to self medicate.

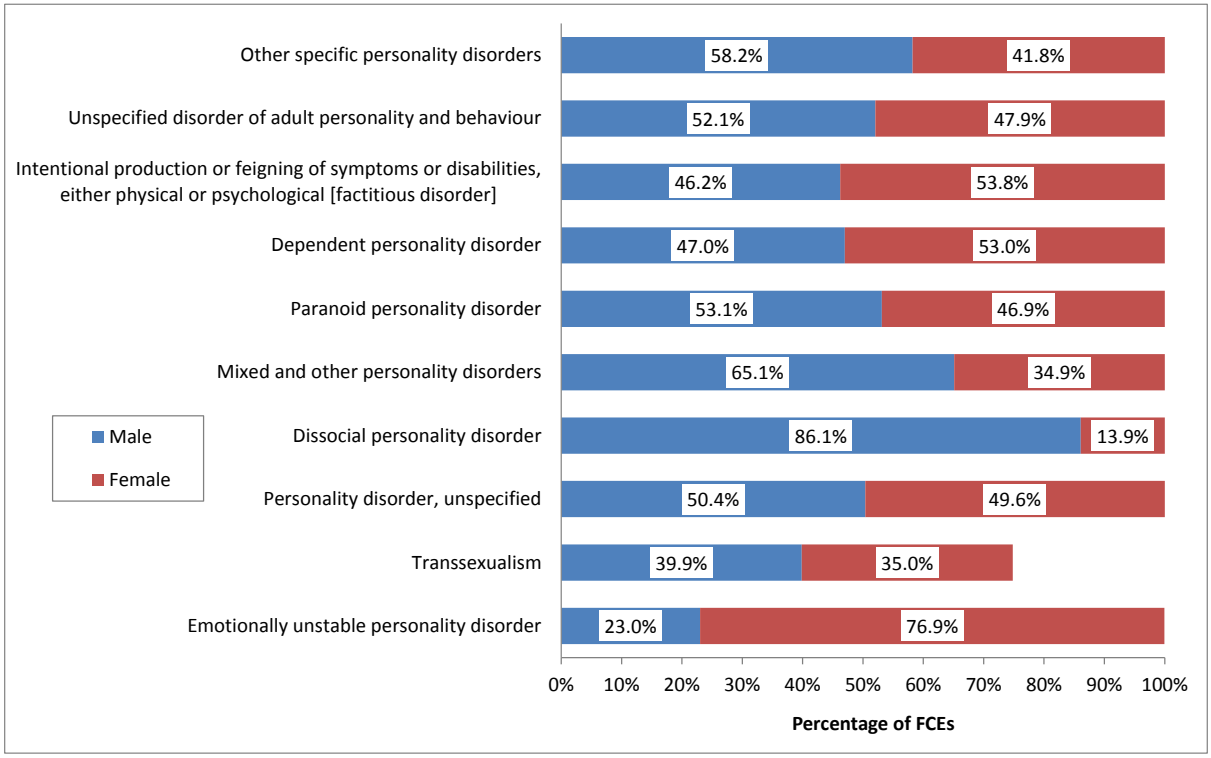
Figure 11: Top Ten Primary Diagnoses of Finished Consultant Episodes for PD. People All Ages, England 2014-15[125]



Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

Figure 11 shows the greatest percentage of primary diagnosis is emotionally unstable (borderline PD) at 77%.

Figure 12: Top Ten Primary Diagnoses of Finished Consultant Episodes for PD. Proportions by Gender, All Ages. England 2014-15[126]



Source: Hospital Episode Statistics. Health and Social Care Information Centre http://www.hscic.gov.uk (Accessed 21st February 2016)

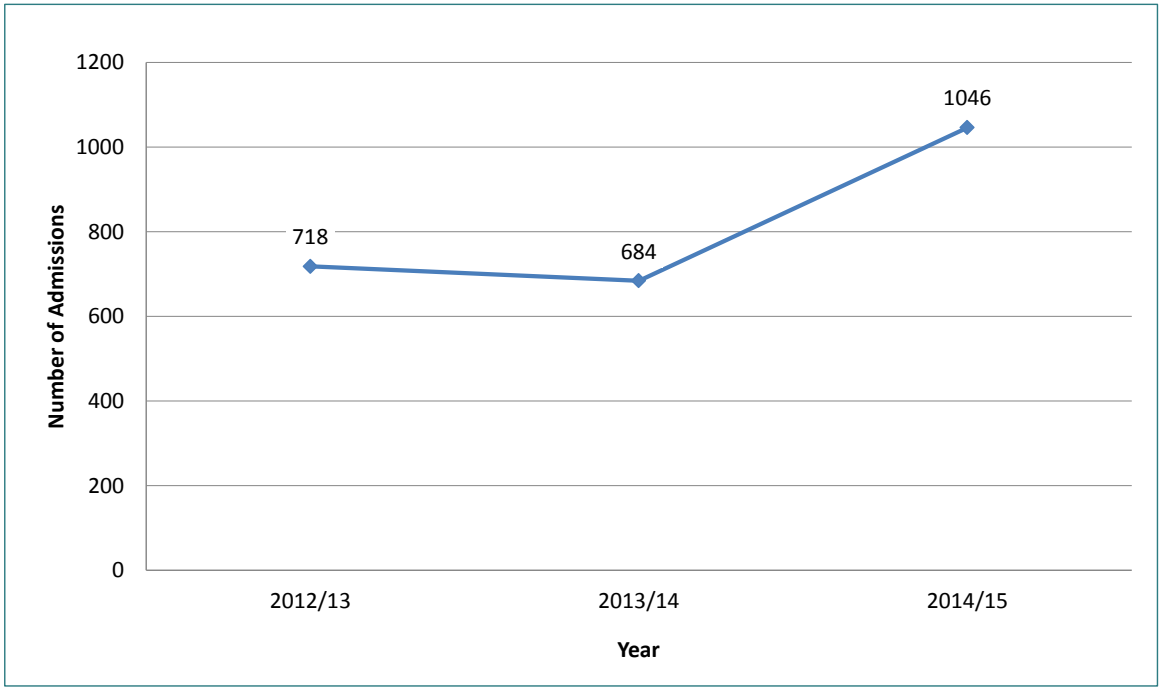
Figure 12 show a clear female dominant gender trend for emotionally unstable personality disorder, with the remainder of diagnoses roughly balanced between genders. The exception is dissocial (antisocial) PD episodes where 86% were male.

3.6 Hospital Admission Activity for Personality Disorder within Kent

3.6.1 Analysis of Data

Hospital admissions data for Kent residents has been systematically analysed for 2012-13 to 2014/-5, enabling the distribution of PD to be identified and any trends revealed. The main age group is 16-74 years. This has been broken down further, however, into five year age brackets where necessary. The analysis has been carried out at Kent level, and broken down further, where appropriate, to district level and CCG level. For the whole Kent population, between 2012-13 and 2014-15, there were a total of 2,527 admissions with a diagnosis of ICD-10 F60-F69 (PD) as the primary diagnosis or in any of the other subsequent diagnosis coding positions.

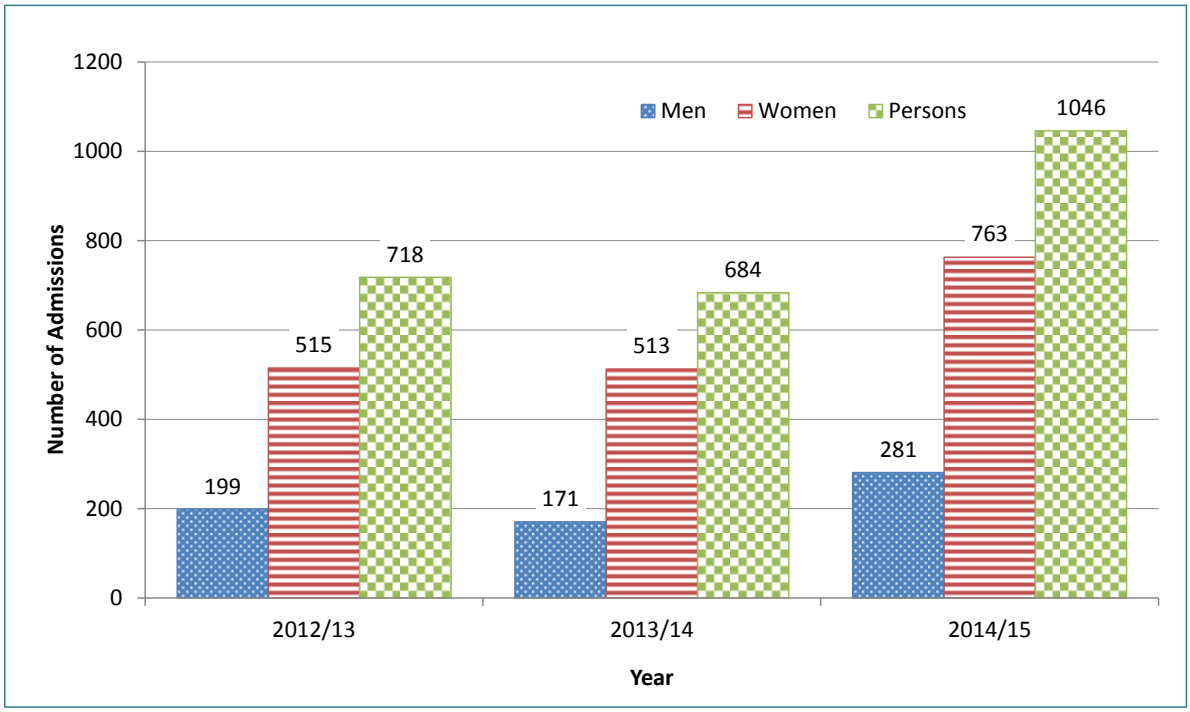
Figure 13: Number of Admissions for PD (Any Diagnosis Field) in Kent. All People Aged 16-74 Years 2012-13 to 2014-15[127]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 13 shows the number of people aged 16-74 admitted for personality disorder with PD in any field. There were a total of 2,448 admissions between 2012-13 and 2014-2015. The number of admissions as seen in Figure 13 is increasing. Admission rates in Kent increased by 46% between 2012-13 and 2014-15 a faster growth than for England, which experienced an increase of 25% in this time[128]. Discussion with KMPT clinicians suggests a better identification of PD is part of the reason for the increased rate for Kent.

Figure 14: Number of Admissions for PD (Any Diagnosis Field) in Kent. All People Aged 16-74 Years by Gender, 2012-13 to 2014-15[129]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 14 shows that, as with the national data on gender, women form the majority of admissions, composing 73% of admissions for PD in Kent.

Table 8: Number of Individuals with and Number of Admissions for PD (Any Diagnosis Field) in Kent. All People Aged 16-74 Years, 2012-13 to 2014-15.[130]

Total Number of Individuals	**1479**
Total Number of Admissions	2448

Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Table 8 shows the number of admissions relating to PD by individuals aged 16-74 years between 2012-13 and 2014-15.

Table 9: Number of Individuals with Repeat Admissions for PD (Any Diagnosis Field) in Kent. All People Aged 16-74 Years, 2012-13 to 2014-15.[131]

Number of Admissions	Number of Individuals
1	1083
2	210
3	92
4	45
5	21
6-10	17
11-41	11

Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Table 9 shows repeat admissions. Eleven individuals in Kent have had between 11 and 41 admissions over a three year period. This is a significant number of people for whom it is important that their current pathway of support is reviewed.

Table 10: Number of Admissions for (PD in Any Diagnosis Field) in Kent by CCG and District Authority Area. All People Aged 16-74 Years, 2012-13 to 2014-15.[132]

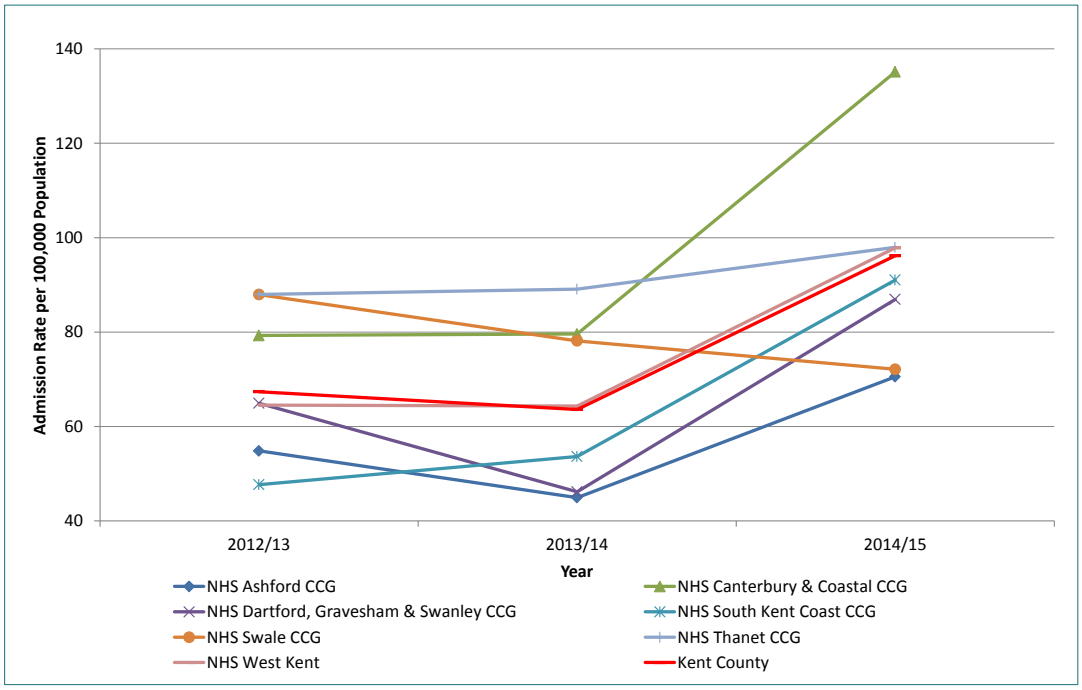
Clinical Commissioning Group / District Authority Area	Number of Admissions
NHS Ashford CCG	**148**
Ashford	148
NHS Canterbury & Coastal CCG	**441**
Canterbury	383
Dover	23
Swale	35
NHS Dartford, Gravesham & Swanley CCG	**361**
Dartford	166
Gravesham	169
Sevenoaks	26
NHS South Kent Coast CCG	**284**
Dover	137
Shepway	147
NHS Swale CCG	**189**
Swale	189
NHS Thanet CCG	**266**
Thanet	266

NHS West Kent	**759**
Maidstone	392
Sevenoaks	49
Tonbridge and Malling	148
Tunbridge Wells	170
Grand Total	**2448**

Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Table 10 shows NHS West Kent CCG has the highest number of admissions reflecting its bigger population.

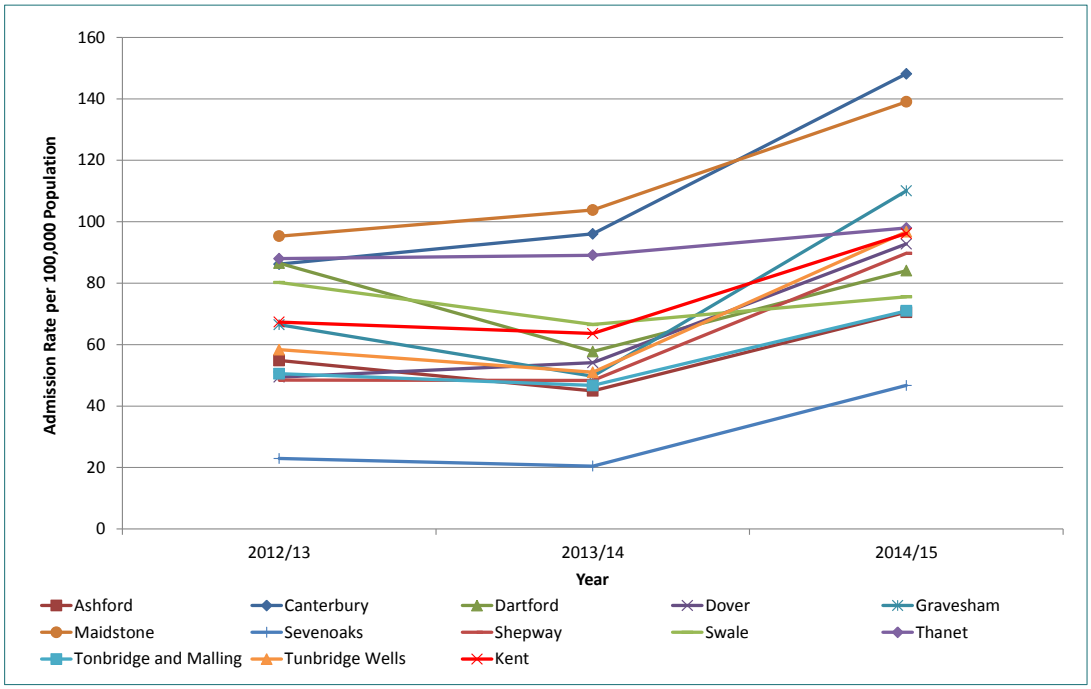
Figure 15: Rates of Admissions for PD (Any Diagnosis Field) in Kent by CCG. All People Aged 16-74 Years, 2012-13 to 2014-15.[133]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 15 shows the rates of admission for PD any diagnosis by CCG which enables a clearer understanding of secondary care activity. Admission rates for PD have increased in all CCG areas between 2012-13 and 2014-15, with the exception of Swale CCG. However, these rates are based on small numbers and so apparent trends must be viewed with caution but the rate for Canterbury is significant.

Figure 16: Rates of Admissions for PD (Any Diagnosis Field) in Kent by District Authority. All People Aged 16-74 Years, 2012-13 to 2014-15.[134]



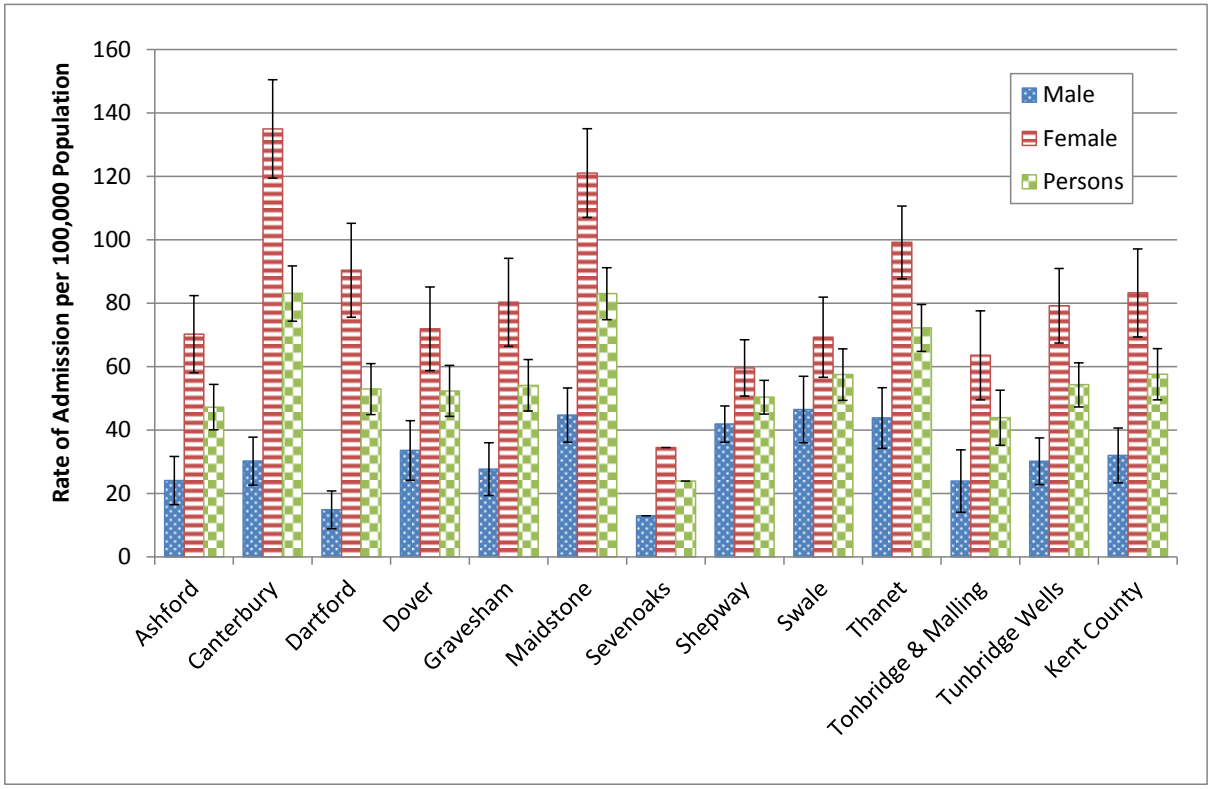
Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 16: shows the rates of admission for PD any diagnosis by local authority which also enables a clearer understanding of secondary care activity. Admission rates for PD have increased over the last three years in all local authority areas between 2012-13 and 2014-15, with the exception of Swale and Dartford. These rates are also based on small numbers, however, and so apparent trends must be viewed with caution.

Kent has an increase in admissions for PD overall of 43%. Thanet has a rise of 11%, Swale has a reduction of -5% and Dartford has a reduction of -3%. These modest changes may be due to the deprivation profile of these communities where clinicians are more aware of PD and have been diagnosing more effectively in communities where we expect to see a higher prevalence.

Canterbury has some deprivation challenges but this is unlikely to account for it having the highest rate of admissions per 100,000 population aged 16-74: a **71%** increase in the last three years. This may reflect better awareness with respect to young people in the clinical community supporting the large student community in this local authority area; young people, particularly young women, are represented in greater numbers for BPD. Canterbury's data would benefit from further investigation.

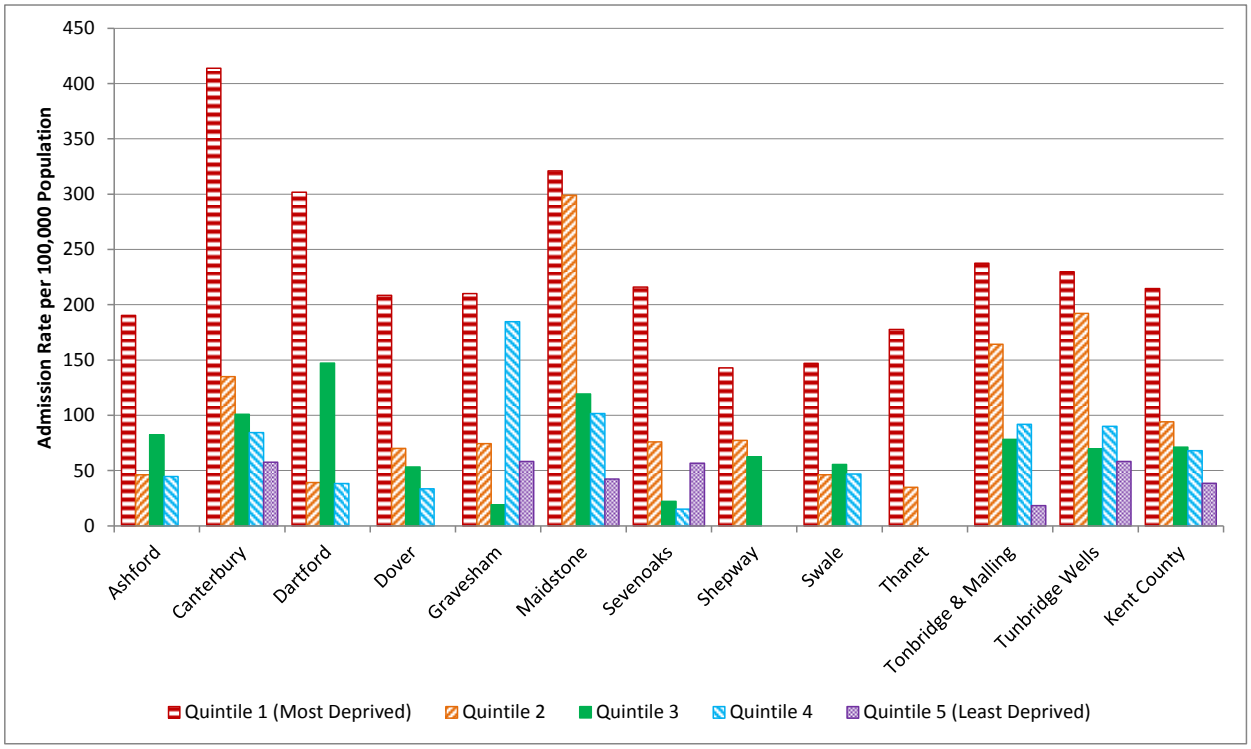
Figure 17: Age Standardised Rates of Admissions for PD (Any Diagnosis Field) in Kent by District Authority. All Ages by Gender, 2012-13 to 2014-15.[135]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 17 shows age standardised admission rates for PD related admissions. To allow for differences in age distribution in Kent, rates have been standardised to the European standard population and shown for males, females and people across all districts in Kent. All districts show females have a higher age standardised rate than males, and Canterbury, Maidstone and Thanet show the highest rates of admission. Canterbury's larger student population will also influence the rate.

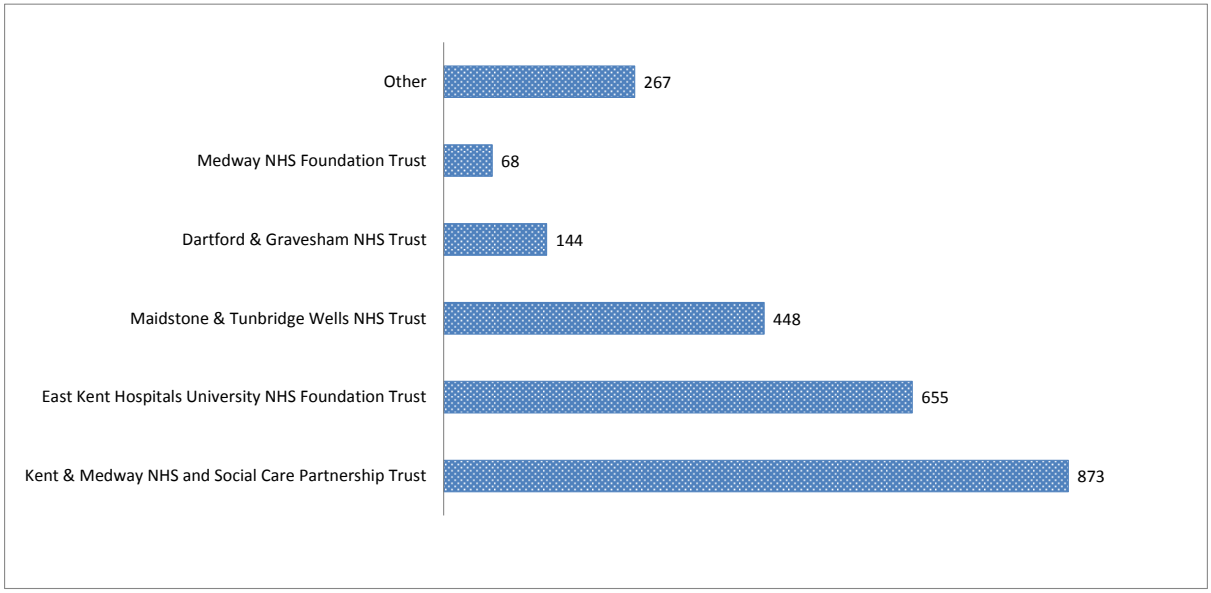
Figure 18: Rates of Admissions for PD (Any Diagnosis Field) in Kent by District Authority and Deprivation Quintile. People Aged 16-74, 2014-15.[136, 137]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)
Department for Communities and Local Government Indices of Deprivation, 2016

Figure 18 shows that the greatest number of admissions come from the most deprived quintiles. There is a clear linear relationship between the admissions and deprivation quintile.

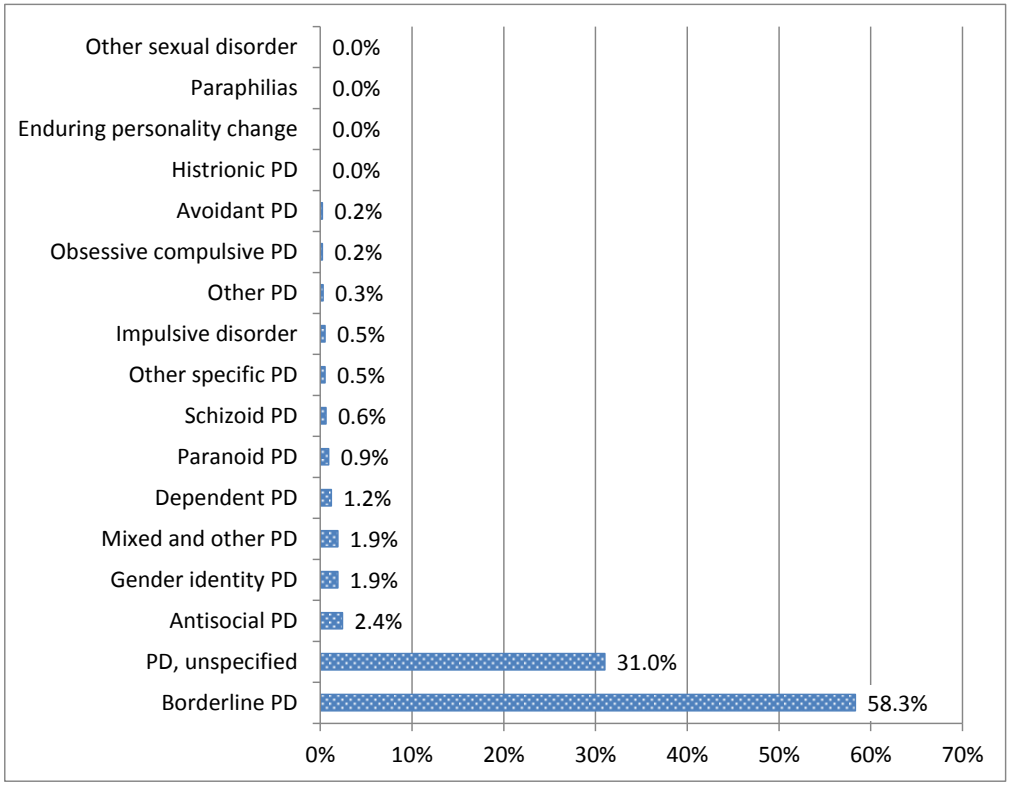
Figure 19: Numbers Admissions for PD (Any Diagnosis Field) in Kent by Provider. People Aged 16-74, 2012-13 to 2014-15.[138]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 19 shows Kent and Medway NHS and Social Care Partnership Trust, the mental health trust for adults in Kent, has the highest number of admissions for PD.

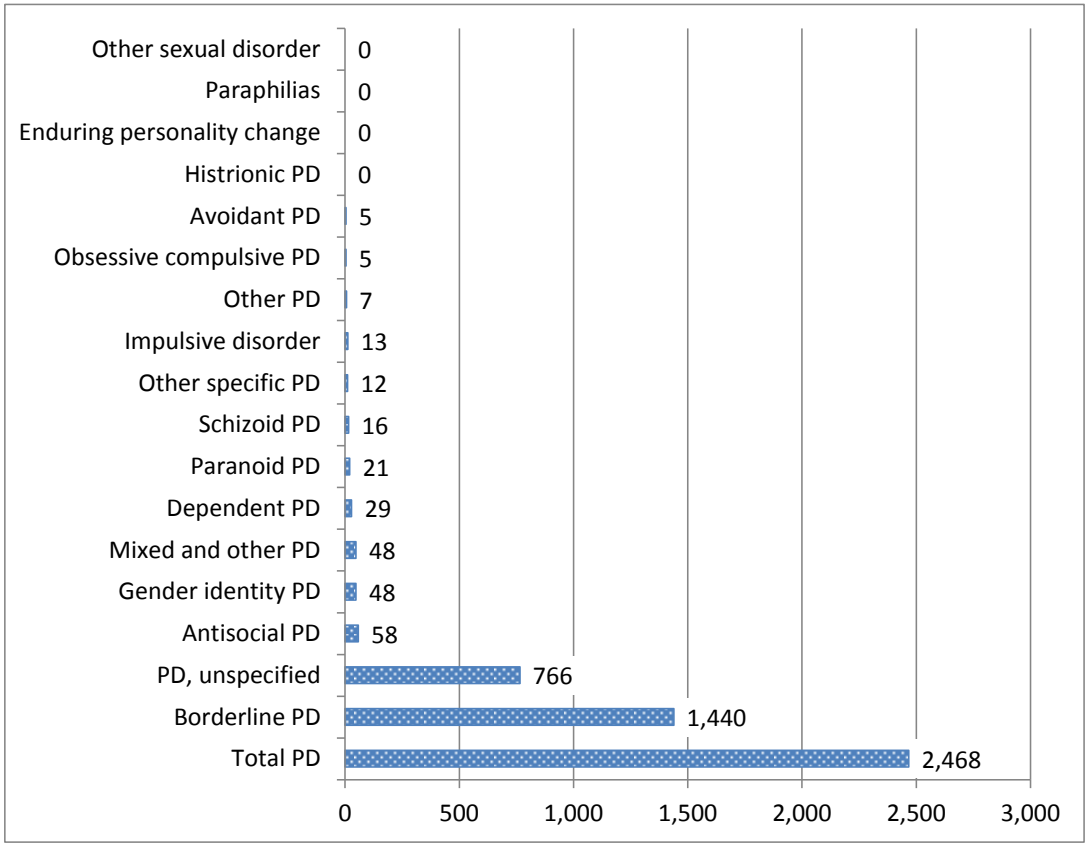
Figure 20: Percentage of Hospital Admissions of People Aged 16-74 by PD Type in Kent, 2012-13 – 2014-15.[139]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 20 shows emotionally unstable or borderline personality disorder has the greatest percentage (58%) of admissions in Kent. Unspecified PD contributes a large percentage (31%) of the admissions; the diagnosis of personality disorders (PD) is a contentious one for psychologists and has recently been reviewed.[140 141]

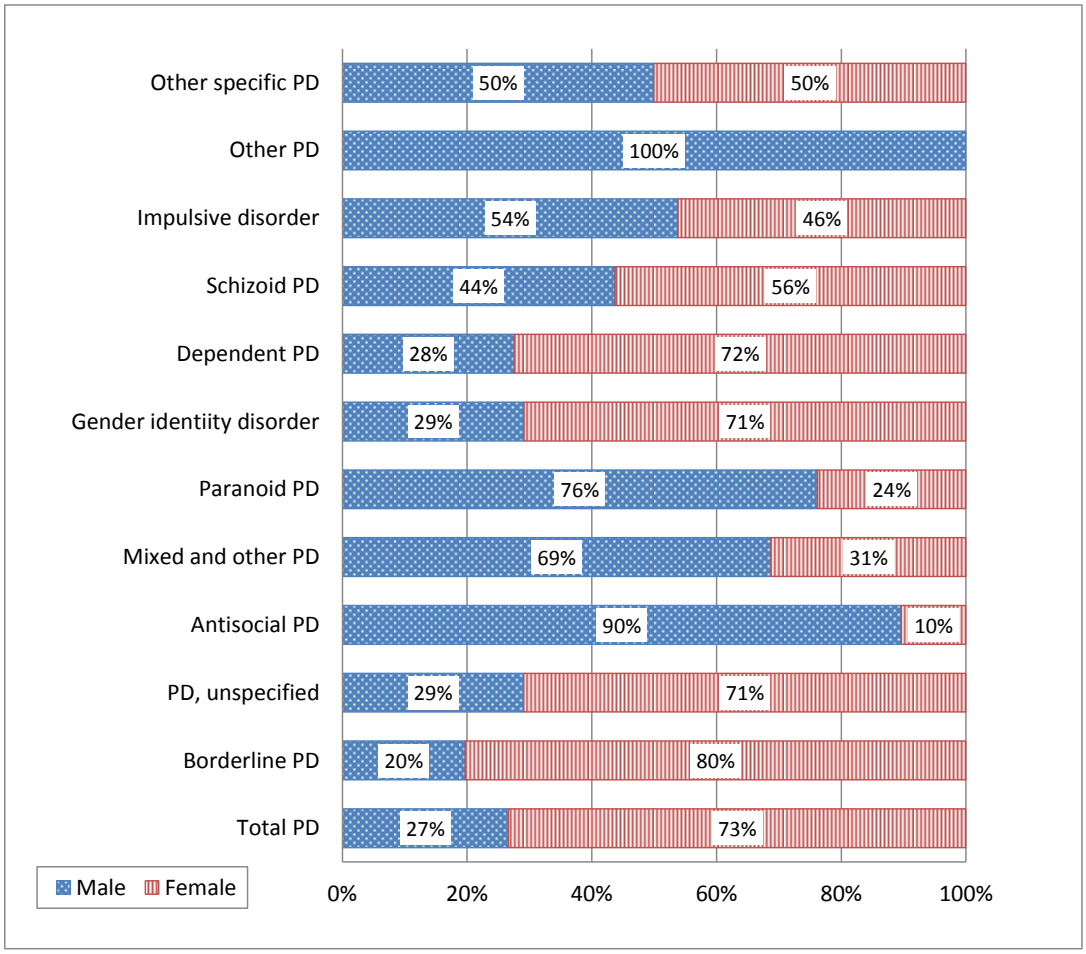
Figure 21: Number of Hospital Admissions of People Aged 16-74 by PD Type in Kent, 2012-13 – 2014-15.[142]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 21 shows the breakdown in diagnoses made for the 2,448 admissions. There were a total of 2,468 diagnoses for PD, suggesting that some admissions contain more than one diagnosis of PD. The main diagnoses are BPD and unspecified personality disorder.

Figure 22: Proportion of Hospital Admissions for PD (Any Diagnosis Field) by Gender. People Aged 16-74 by PD Type in Kent, 2012-13 – 2014-15.[143]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 22 shows the total PD population described of which 73% are females and 27% males. This pattern is also seen with BPD although an even greater proportion, 80%, of females make up the population diagnosed with BPD, compared to 20% of males. A male dominant split is seen for unspecified PD, and 90% of people diagnosed with dissocial PD are male and only 10% female. Similar patterns of majority male proportions are seen for mixed PD and paranoid PD. NICE BPD guidance suggests that studies of BPD in the community have found BPD is equally prevalent in both genders and therefore commissioners need to review why there is a smaller prevalence for men in SUS data; could it be they are presenting in other services such as substance misuse or the criminal justice system?

In Kent, inpatient activity for PD related admissions suggests women are 2.7 times more likely to present with BPD than men. Eating disorder and people presenting with chronic self harming behaviour are some of the key diagnostic criteria for BPD.[144] However, NICE guidance notes the prevalence is roughly equal between genders suggesting men may be

under-represented in services. BPD is particularly common among people who are drug and/or alcohol dependent, and within drug and alcohol services more men access the services than women.

Table 11: Top Ten Secondary Diagnoses (First Position) for Finished Consultant Episodes with Primary Diagnosis of PD. People Aged 16-74, 2012-13 – 2014-15.[145]

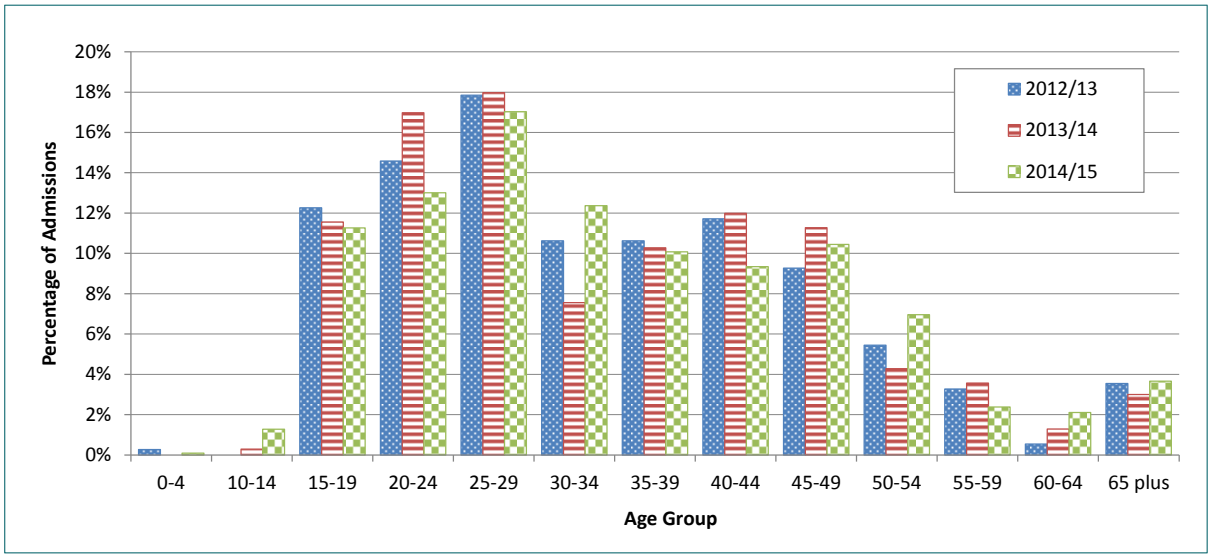
Secondary Diagnosis (First Position)	Number of FCEs
Mental & behavioural disorders due to tobacco: harmful use	121
Personal history of self harm	75
Unknown	52
Mental & behavioural disorders due to alcohol: harmful use	27
Mental & behavioural disorders due to alcohol: dependence syndrome	25
Depressive episode, unspecified	24
Mental & behavioural disorders due to cannabinoids; harmful use	21
Mental & behavioural disorders due to multiple/psychoactive drugs: harmful use	20
Personal history of noncompliance with medical treatment and regimens	20
Posttraumatic stress disorder	16

Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Table 11 shows there are significant numbers of PD patients who self harm, and have harmful drug and alcohol behaviours, which underline the challenge of dual diagnosis and the need for shared pathways and protocols such as have been agreed in Kent. The Mental Health JSNA notes that dual diagnosis, i.e. the coexistence of mental illness with substance misuse, complicates management and is associated with poorer outcomes. It is estimated that 20% of clients accessing substance misuse services in Kent are affected by dual diagnosis.[146] It is not yet clear what the issues are behind the high tobacco harmful use figure.

The Kent Suicide Prevention Strategy needs to consider this PD needs assessment as part of its ongoing review of the suicide risk for people in contact with mental health services in Kent

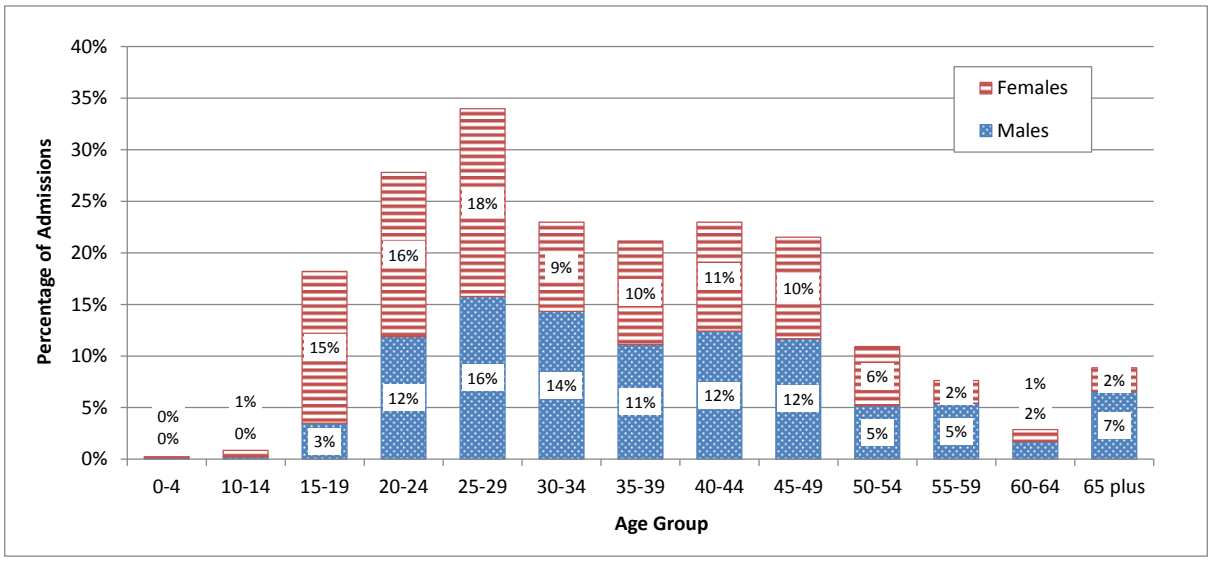
Figure 23: Percentage of Admissions for PD (Any Diagnosis Field) in Kent by Five Year Age Group, People All Ages 2012-13 – 2014-15.[147]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 23 shows that the percentage of admissions for the 15-29 age group is reducing but has increased in the 30-34 age group. Commissioners should monitor this and ensure interventions for young people continue to support a reduction in admissions.

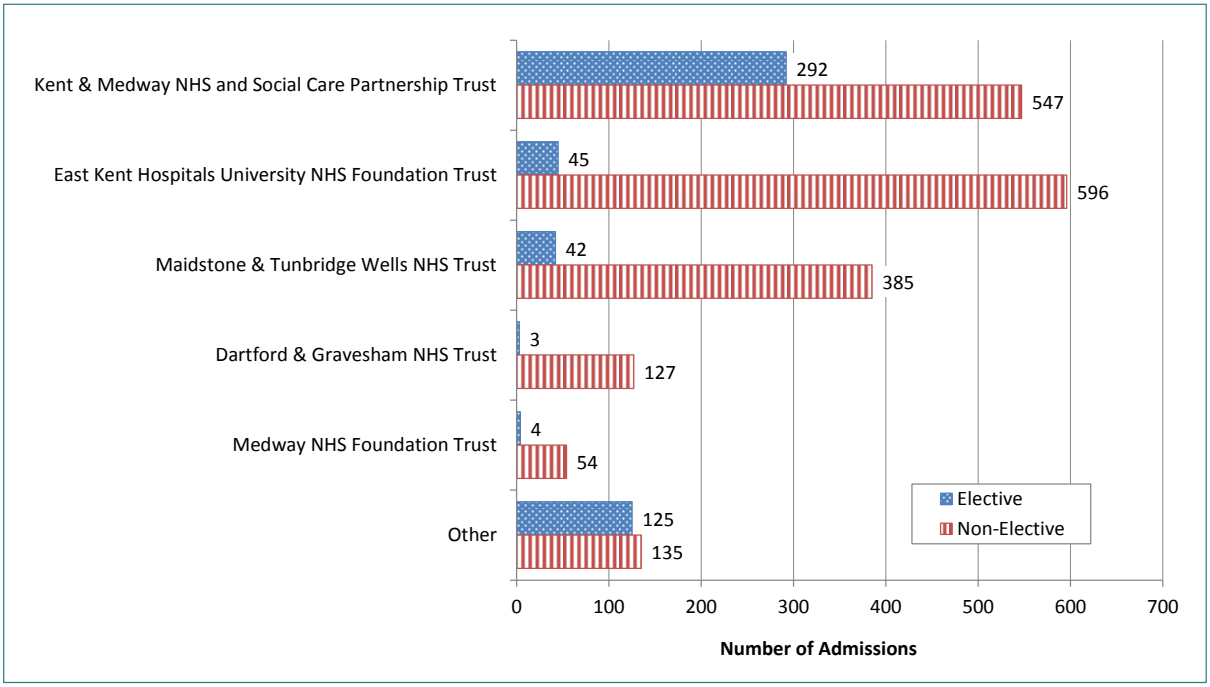
Figure 24: Percentage of Admissions for PD (Any Diagnosis Field) in Kent by Five Year Age Group and Gender, People All Ages 2012-13 – 2014-15.[148]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 24 shows the percentage of admissions remains fairly constant between the genders with a higher percentage for females aged 15-19 and males aged over 55.

Figure 25: Number of Elective and Non Elective Admissions for PD (Any Diagnosis Field) by Provider Trust in Kent. Residents of Kent Aged 16-74, 2012-13 – 2014-15.[149]

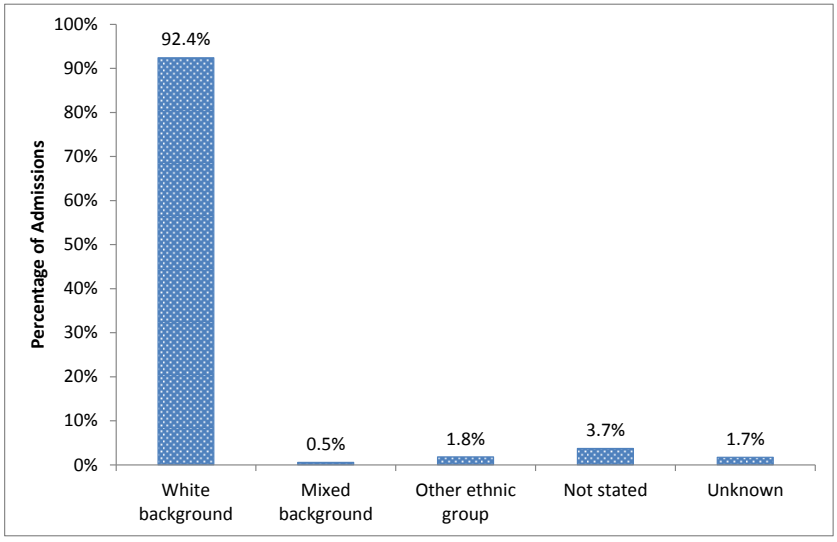


Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

Figure 25 shows the higher number of non elective admissions for PD at all three acute trusts in Kent and at the Kent and Medway Partnership Trust (KMPT). The commissioners need to understand better the pathways for the high numbers of non elective admissions in East Kent Hospitals and Maidstone and Tunbridge Wells Trusts and to explore if interventions earlier on the pathway can reduce numbers of people presenting to urgent care in crisis.

Clustering challenges using Mental health Payment By Results was mentioned in the data section of this report's introduction. KMPT clinical leads are aware the data has significant quality issues that need to be taken into account & exception reported. For example, in a recent survey (2016) only 109 of the 407 open referrals to specialist PD services in KMPT have a cluster 6 or 8 diagnosis which suggests clustering inaccuracies.

Figure 26: Proportions of Admissions for PD (Any Diagnosis Field) by Ethnicity in Kent. People Aged 16-74, 2012-13 – 2014-15[150]



Source: Hospital Episode Statistics. Secondary Uses Service (SUS)

The overall population of Kent is comprised of 90% white, 1% mixed race and 9% other ethnic groups. Figure 26 shows the proportions of admissions for PD by ethnic group and may highlight an underrepresentation of non white minorities. However, this may be compounded by incomplete data recording at admission, where often ethnicity is stated as "not stated" or "unknown".

Commissioners need to understand better the pathways for the high numbers of non elective admissions in East Kent Hospitals and Maidstone and Tunbridge Wells Trusts and to explore if interventions earlier on the pathway can reduce numbers of people presenting to urgent care in crisis

3.7 Support for people with personality disorder in prison.

Between 50% and 78% of adult prisoners are believed to meet criteria for one or more personality disorders, and even higher prevalence estimates have been reported among young offenders.[151]

NICE states that criminal behaviour is central to the definition of antisocial personality disorder, although it is often the culmination of previous and longstanding difficulties, such as socioeconomic, educational and family problems. ASPD therefore amounts to more than criminal behaviour alone; otherwise everyone convicted of a criminal offence would meet the criteria for ASPD and this diagnosis would be rare in people with no criminal history. This is not the case. The prevalence of ASPD among prisoners is slightly less than 50%. Community epidemiological studies suggest that only 47% of people who meet the criteria for ASPD have significant arrest records. A history of aggression, unemployment and promiscuity are more common than serious crimes among people with this disorder. The

prevalence of antisocial personality disorder in the general population is 3% in men and 1% in women. [152]

Table 12 Percentage of the UK Prison Population with Personality Disorders, 2007.[153]

	Prison Group		
	Male Remand	**Male Sentenced**	**Female Prisoner**
Borderline personality disorder	23%	14%	20%
Antisocial personality disorder	63%	49%	31%
Any personality disorder	78%	64%	50%

Source: APMS 2007 Summary Report

Table 13 Estimated Number of Inmates with PD in Kent Prisons.[154], [155]

HM Prison	Category	Capacity	Estimated Numbers with PD		
			BPD	ASPD	Any PD
Blantyre House, Goudhurst	Adult male. Category 'C/D'. Resettlement of long-term prisoners.	122	17	60	78
East Sutton Park, Maidstone	Adult and young offender female. Open prison.	100	20	31	50
Elmley (Sheppey Cluster)	Local Prison. Male Category 'C'.	1252	175 - 288	613 - 789	801 - 977
Standford Hill (Sheppey Cluster)	Male Category 'D'. Sentenced adults.	462	65	227	297
Swaleside (Sheppey Cluster)	Male Category 'B'. Training Prison.	1132	156 - 256	545 - 701	712 - 867
Maidstone	Male Category 'C'. Training prison.	600	84 - 138	294 - 378	384 - 468
Total		**3668**	**517 - 784**	**1771 - 2186**	**2322 - 2737**

Source: APMS 2007 Summary Report HM Prisons Service

There is a high prevalence of people with PD in the criminal justice system[156]. It is understood that NHS England is shortly undertaking a needs assessment of personality disorder in prisons in Kent which will inform a future version of this needs assessment. In addition data should become available relating to PD in the National Offender Management

System to help inform the needs assessment for Kent residents during transition from prison.

NHS England is taking forward the recommendations in the *Standards for Prison Mental Health Services,* and will set out how the PD element is monitored and how pathways developed for prisoners returning to their communities in Kent are evaluated. In particular what progress is planned relating to recommendations on:

- recommending further treatment available for prisoners with personality disorder
- specialist services for prisoners with a sole diagnosis of personality disorder and improved services for those with a dual diagnosis.[157]

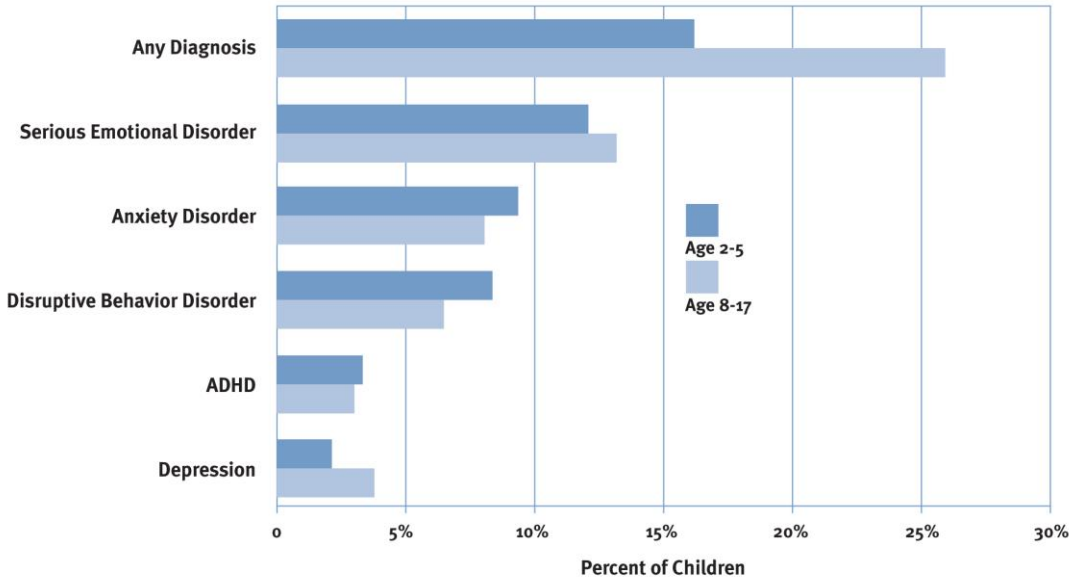
In addition we will have insight into the actions have been taken or are planned relating to the other prison health standards in the context of personality disorder.[158]

4.0 The Prevention of Personality Disorders

4.1 Children and Young People

Conduct disorders can occur early in infancy at a similar rate as later in childhood. Children who experience negative parenting, poor quality relationships and other adversity in early life are at particular risk of a number of poor outcomes later on, including mental health problems

Figure 27: Mental Health Problems can Occur across Childhood: The Pattern of Common Child Psychiatric Disorders in 2-5 Year Olds and 8-17 Year Olds



Source: Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology Egger & Angold, Journal of Child Psychology and Psychiatry (2006)

Figure 27 shows that the rates of the common child psychiatric disorders and, in addition, the patterns of comorbidity among them in preschool children are similar to those seen in later childhood. [159] This is despite the relative lack of research on preschool psychopathology compared with studies of the epidemiology of psychiatric disorders in older children. It may be that more research needs to focus on preschool children's mental health. [160] Research should grow our understanding of attachment theory including the benefits of breastfeeding in fostering early attachment and other public health challenges facing society that influence the cognitive ability and mental health of babies and children.[161] [162]

Conduct disorders are the most common mental disorder in children and young people and half go on to develop ASPD as adults.[163] This disorder is also associated with a 70 fold increased risk of being imprisoned by the age of 25.[164] The most antisocial 5% of children aged seven years are 500 to 1,000% more likely to display indices of serious life failure at 25 years, for example drug dependency, criminality, unwanted teenage pregnancy, leaving school with no qualifications, and unemployment.[165]

The National Institute of Health and Clinical Excellent notes the prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls. Prevalence rates are also linked to deprivation, with a 3- to 4-fold increase in prevalence among children from more deprived households compared with those in the most affluent. Almost 40% of looked-after children, those who have been abused and those on child protection and safeguarding registers have been identified as having a conduct disorder.[166]

Studies show that toddlers who have secure, trusting relationships with parents or non parent caregivers experience minimal stress hormone activation when frightened by a strange event, and those who have insecure relationships experience a significant activation of the stress response system. Good parent child or carer child relationships promote emotional, social and cognitive development, emotional resilience and healthy lifestyles. They are also associated with increased resilience against a range of difficulties, including mental illness. When support for the child and carer is needed it is more successful when it builds on positive parenting. There are a number of well validated evidence based parent support programmes available.[167, 168]

Partners need to be aware of the risks of conduct disorder that children face in their early years and the importance of minimising childhood trauma. Prevention should focus on providing a nurturing, supportive and consistent home environment with a balance of love and discipline to help reduce symptoms and sometimes prevent episodes of difficult behaviour in children.[169] Many of the problems associated with conduct disorder can be minimised with early intervention.[170]

4.2 Prevention of Conduct Disorders in Children and Young People

What happens in early childhood can matter for a lifetime and our knowledge of the early developmental origins of health has grown. In pregnancy, babyhood and toddlerhood or early childhood, research on the biology of stress shows how major adversity, such as extreme poverty, abuse, or neglect can weaken developing brain architecture and permanently set the body's stress response system on high alert.[171] Science also shows that support to provide stable, responsive, nurturing relationships in the earliest years of life can prevent or even reverse the damaging effects of early life stress, with lifelong benefits for learning, behaviour, and health.[172]

The prevention of BPD has growing evidence. Data also suggest considerable flexibility and malleability of BPD traits in particular in young people. This makes youth a key developmental period during which to intervene. Prevention and early intervention programmes have shown that BPD in young people responds to intervention but more research is needed to develop appropriate universal and selective preventive interventions.[173]

Children in socioeconomically disadvantaged households in early childhood are twice as likely than the least disadvantaged children to develop a disabling condition in later childhood.[174]

The Children and Adolescent Mental Health Services (CAMHS) Needs Assessment for Kent explores the issue of deprivation which increases the numbers and rates of mental health conditions for children and young people in areas such as Shepway, Swale and Thanet. For instance the rate of conduct disorder in Thanet is 8.1%: that is, about one in 12 children and adolescents aged 5 to 16. This is nearly double that of the adjusted rate for Tonbridge and Malling of 4.1%.[175] In terms of equity, the CAMHS needs assessment notes that there appears to be a lower proportion of 5 to 10 year olds within CAMHS services than would be expected. This needs to be followed up.

Known factors that require mitigation due to their association with a higher risk of developing conduct disorders include parental factors such as harsh and inconsistent parenting style and parental mental health problems (for example depression, antisocial personality disorder and substance misuse), environmental factors such as poverty and being looked after, and individual factors such as low educational attainment and the presence of other mental health problems.[176]

Borderline PD symptoms may be more amenable to treatment in childhood and adolescence than in adulthood.[177]Clinical research has demonstrated that significant reductions in borderline symptoms and associated dysfunction can be gained through interventions during the adolescent years .[178]

Services across England have recently been reviewed by OFSTED with recommendations to make them more effective and safe.[179] KCC Early Help and Preventative Services (EHPS) have extensive parent and child support programmes [180] and their impact on children in households where domestic violence, parental drug and alcohol misuse and parental mental ill-health exist is under constant review.[181] [182] Its important to note if a parent suffers from the toxic trio this does not on its own automatically indicate that their children are at risk of abuse or neglect. National research shows, however, that the indication of the toxic trio in parents is very low at the referral stage.[183]

A good relationship between the child's parents is also important: children of these parents tend to have high levels of wellbeing. In general, whether parents remain together or not,

the quality and content of fathers' involvement matters more for children's outcomesthan simply how much time they spend with their children.[184] OFSTED noted across early help services it was not clear what evidence there was of support for fathers' involvement.[185] OFSTED's main recommendations that have been noted by KCC were toimprove the quality and consistency of assessment and plans by:

- promoting the use of evidence and researc-informed assessment practice
- improving the quality of analysis in assessments
- ensuring that assessments reflect the views and experience of the child and family
- making the purpose clearer and improving the intended outcome
- ensuring plans are regularly reviewed and that these reviews evaluate the child's and family's progress
- providing professional supervision to all staff delivering early help and ensuring that their work receives regular management oversight, particularly in respect of decisions about whether families need more formal help
- ensuring that all early help professionals have access to effective training
- ensuring that children's needs for early help arising from parental substance misuse, mental ill health and domestic abuse are addressed in commissioning plans.[186]

Recommendations for improved delivery of parent support place emphasis on health promotion, prevention and early intervention, adopting the principle of progressive universalism and advocate that screening, surveillance and other measures are implemented within the approach. In particular, it is important to ensure that screening is linked to appropriate support and intervention and is carried out in a supportive and sensitive manner to avoid a sense of parents being or feeling stigmatised, for example because of their own mental health problems.[187]

4.3 Treatment Interventions for Conduct Disorders in Infancy, Childhood and Adolescence

The emotional and behavioural needs of vulnerable infants, toddlers, and preschool children are best met through coordinated services that focus on their full environment of relationships, including parents, extended family members, health visitors, providers of early care and education, and/or mental health professionals. Mental health services for adults who are parents of young children would have broader impact if they routinely included attention to the needs of the children as well.[188]

Early childhood interventions in the first five years of a child's life tend to show links to a broad range of positive outcomes. These include higher cognitive skills, school attainment, higher earning capacity, health and mental health benefits, reduced maltreatment and, significantly for this guideline, lower rates of delinquency and crime. NICE notes that early childhood interventions are quite unique in this regard: there are no other interventions that have generated such a broad set of positive outcomes.[189] The impact of intervention

extends beyond educational performance to criminal behaviour and this is not surprising given the well documented relationship between educational outcomes and adult mental health and social behaviour.[190]

A database of programmes available in the UK and the evidence to support them has been developed by the National Academy for Parenting. [191] Two NICE reviews have been produced: one relating to parenting programmes to prevent and treat conduct disorder[192] and one in relation to supporting social and emotional development in the vulnerable under fives.[193,194]

4.4 Incredible Years and Triple P

As noted, the evidence base for support for parents and carers is growing and NICE has published some guidance on the promotion of emotional and social development in vulnerable under fives;[195] this includes the well evidenced Incredible Years programme[196] and Triple P. [197] Triple P has demonstrated impact in public health terms of both a universal and targeted approach and research suggests a strong economic case for investing in these interventions.[198]

Like the Incredible Years Programme, Triple P gives parents simple and practical strategies to help them confidently manage their children's behaviour, prevent problems developing and build strong, healthy relationships. [199] Two large trials of Triple P offered at all levels[200, 201] are among the few studies to have demonstrated impact of a universal and targeted approach combined; the first[202] is one of a small number of studies to have shown any effect on abusive parenting. Triple P includes five intervention levels of increasing intensity and narrowing population reach. The system was designed to enhance parental competence, and prevent or alter dysfunctional parenting practices, thereby reducing an important set of family risk.

In middle childhood, from 8 to 11 years, the behavioural features of concern mentioned above are often present, but as the child grows older and stronger and spends more time outside the home other behaviours are seen. They include swearing, lying about what they have been doing, stealing others' belongings outside the home, persistent breaking of rules, physical fights, bullying other children, being cruel to animals and setting fires. Parenting programmes are flagged as the key intervention alongside group social and cognitive problem solving programmes to children and young people aged between 9 and 14 years who have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder **or** have oppositional defiant disorder or conduct disorder **or** are in contact with the criminal justice system because of antisocial behaviour.[203, 204]

In adolescence, from 12 to 17 years, more antisocial behaviours are often added: being cruel to and hurting other people and animals, assault, robbery using force, vandalism, breaking and entering houses, stealing from cars, driving and taking away cars without

permission, running away from home, truanting from school, and misusing alcohol and drugs. NICE recommends multimodal interventions should be offered, for example, multisystemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder. The goal of multi systemic therapic (MST) is to break the cycle of antisocial behaviours by keeping young people safely at home, in school, and out of trouble. MST works to increase the skills and resources of the parents and carers to manage young person's behaviours more effectively.[205]

Not all children who start with the type of behaviours listed in early childhood progress on to the later, more severe forms. Only about half continue from those in early childhood to those in middle childhood; likewise only about a further half of those with the behaviours in middle childhood progress to show the behaviours listed for adolescence.[206] However, the early onset group are really important as they are far more likely to display the most severe symptoms in adolescence, and to persist in their antisocial tendencies into adulthood.

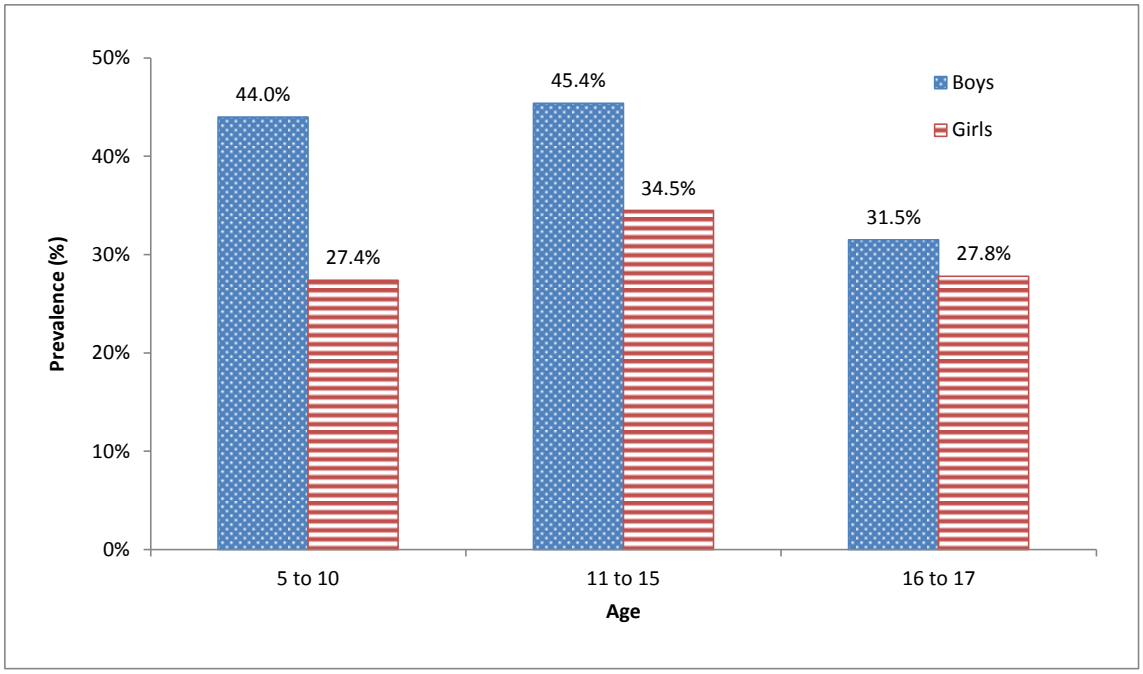
The economic case is strong and the evidence is compelling for addressing child and adolescent mental health. [207] The estimated lifetime cost of severe behavioural problems and ADHD is £280,000 per child, and £1,070 million for each one year cohort of children in England respectiveley based on use of health and sopcial care services, educational provision , crime and reduced lifetime earnings (2012/2013 prices). [208] This is comnpared with the average estimated cost of delivering a 8-12 week parenting programme for the prevention of persistent conduct disorders, such as Triple P and Incredible Years, which is around £1,213 per family using 2013/14 prices. [209]

NICE in 2012 noted that more research is needed as studies of universal programmes have struggled to show impact, possibly because of the problems of applying randomised controlled trials (RCTs) , and there have been few studies related to impact on particular minority ethnic groups and on children whose parents have mental health problems.[210]

4.5 Looked After Children and Conduct Disoders

Looked after children have a high prevalence of conduct disorders; there is a separate Kent Children in Care Needs Assessment on the KPHO website.[211]

Figure 28: Looked After Children: Prevalence of Conduct Disorder by Age and Gender, 2003[212]



Source: Child's personal characteristics: Mental health of young people looked after by local authorities in England (2003)

Thirty six percent of 5-10 year olds looked after by local authorities had clinically significant conduct disorders compared to 5% of children this age living in private households. Figure 28 shows that in the age group 11-15, 40% of looked after children were diagnosed with conduct disorders compared to 6% in private households (private household data for 16 to 17 year olds is unavailable).[213]

KCC Social Care services have significant involvement with children and young people with conduct disorders, with more vulnerable or disturbed children often being placed with a foster family or, less commonly, in residential care. The demands on the educational system are also considerable and include the provision of special needs education. The criminal justice system also has significant involvement with older children with conduct disorders. Given that these individuals are in the "revolving door" syndrome and the fact that Kent (and Medway) prisons are to be local prisons filled with local offenders then there needs to be linkage with prison healthcare & HMPS to ensure continuity of care from prison to community.

Table 14: Child Reoffending Rate Cohort by Population Type, Gender & Legal Status

Population Type	Males		Females		Binary Re-offending Rate (%)
	Number	%	Number	%	
Re-offenders	332	76.9	100	23.2	37.0
Cohort excl. out of area looked after children	306	77.3	90	22.7	36.4

Kent looked after children	44	69.8	19	30.2	50.8
Out of area looked after children	26	72.2	10	27.8	44.4
Binary rate (%)	40.1	-	27.0	-	-

Source: Kent Youth Justice Services Analysis of Re-offending July to September 2013 Cohort

The table above sets out a KCC study of all children and young people, who, during Quarter 2 (July to September) of 2013 reoffended.[214] The cohort is made up of **432** children and young people, including looked after children placed in the county by other Local Authorities (OLAC), who committed 505 further offences in the twelve months subsequent to their entry to the cohort. The table details the binary rate of reoffending by gender, identifying that the rate for males was 13 percentage points higher than that recorded for females:

(i) Males 40.1%

(ii) Females 27.0%

It was beyond the scope of the Kent 2013 cohort study to explore the physical and mental health of the reoffending cohort but it is likely significant numbers had a diagnosis of conduct or an associated disorders; further studies could be encouraged to understand if they had conduct and related disorders in their early years. Further work is needed to understand better what further mental health and family support can be made available both to prevent offending and to prevent reoffending.

Studies show that most children and young people with conduct disorders had prior oppositional defiant disorder and almost all adults with ASPD had prior conduct disorders. Of severe, recurrent adolescent offenders, 90% showed marked antisocial behaviour in early childhood.[215] In contrast, there is separately a large group who only start to be antisocial in adolescence but whose behaviours are less extreme and who tend to become less severe by the time they are adults.[216]

Reducing the number of first time entrants into the youth justice system should be a priority for local authorities reducing costs to education health and social care.[217] In England 5.8% of children and young people (CYP) have clinically significant conduct disorders, 3.7% have clinically significant emotional disorders and 1.5% have clinically significant hyperkinetic disorders.[218]

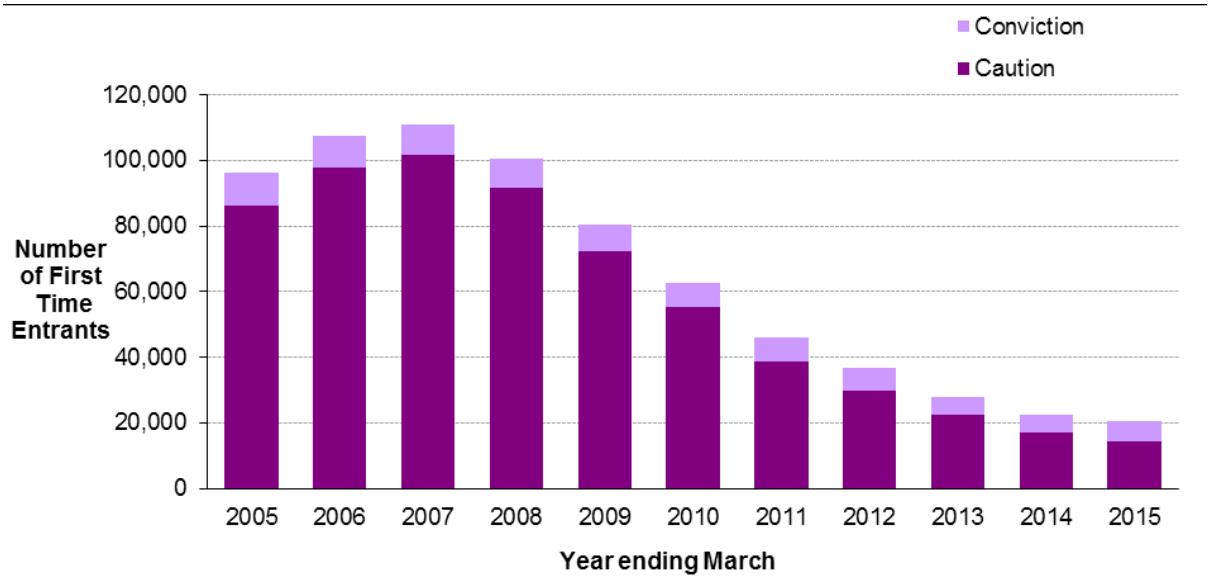
It may be that further support should be made available to assist young people with conduct disorders to access the support they need. Behavioural and cognitive behavioural group based parenting interventions are effective and cost effective for improving child conduct problems, parental mental health and parenting skills in the short term. The cost of programme delivery is modest when compared with the long term health, social, educational and legal costs associated with childhood conduct problems. Preventing

conduct disorders in children who are most disturbed would save £150,000 per case in lifetime costs and that promoting positive mental health in children with moderate mental health would produce a lifetime benefit of around £75,000 per case. [219] There is increrasing evidence of the effectiveness of early interventions [220] and further research is needed on the long term assessment of outcomes.[221]

The key factors associated with youth offending are: poor education and employment prospects, inconsistent parenting, poor housing or homelessness, poor physical and mental health, poor access to financial resources, peer pressure, anti-social behaviour (including conduct disorder);, drug and alcohol abuse, and difficulties in forming and sustaining relationships.[222]

The primary aim of the youth justice system is to prevent youth offending, and the effectiveness of the system is therefore judged in part on its progress in reducing the number of young people entering the criminal justice system for the first time.[223, 224]

Figure 29: The Number of First-Time Entrants into the Youth Justice Sytem in England and Wales, 2005 to 2015



Source: Youth Justice Board / Ministry of Justice Statistics Bulletin, Youth Justice Statistics 2015-16, England and Wales 28 January 2016

Figure 29 shows how the agencies responsible for delivering youth justice have achieved substantial reductions in the number of first-time entrants. The 2014-15 figure of 20,544 represents an 82% reduction from that of its peak in 2006/07. Could more be done to link conduct disorder prevention and justice agency interventions?

KCC has a separate needs assessment for Children and Young People available.[225] NICE has also produced and reviewed its guidance on Looked After Children.[226] In its recommendations NICE stresses the need to have a high level of understanding of

attachment theory, and the impact of trauma and loss on child development and the forming of attachments: these are key risk factors to consider for child conduct disorders. NICE has also published guidance on antisocial behaviour and conduct disorders in children and young people stressing the importance of work on attachment disorers.[227] [228]

The Kent 2015 **Health Needs Assessment Of Children In Care notes that o**verall the CAMHS service for looked after children was felt to be a good service. CAMHS for Children in Care is mainly a support service for foster parents and to a lesser degree offers direct work with looked after children. There may currently be insufficient capacity in the service. The service does not have access to a child psychiatrist. An important issue is the long term impact of poor attachment of young people who have suffered from inconsistent parenting (e.g. parents with mental health issues) throughout their childhood. By the time they enter care as teenagers, they are likely to have difficulties with school, and be using alcohol and illicit substances. Some foster carers find it difficult to deal with these children.[229]

In summary. Children and adults in deprived communities are at greater risk of personality disorder. Neuroscience shows us the pivotal importance of the first few years of life in determining the adults we become, we must think much more radically about improving family life and the early years. A database of programmes available in the UK and the evidence to support them has been developed by the National Academy for Parenting. NICE reviews relating to parenting programmes to prevent and treat conduct disorder are available[230] and NICE Guidance on supporting social and emotional development in the vulnerable under fives.[231, 232] We know that many people in poverty have specific, treatable problems such as alcoholism, drug addiction, poor mental health and we've got to offer the right support, including to those in crisis.[233]

Where possible, interventions need to build on positive parenting: a child's early experiences lay the foundations for their future life chances. Although everyone is born with their own genetic make-up, these genes interact with the family and the environment to determine a child's future health and resilience. The interaction between genetic predispositions and sustained, stress-inducing experiences early in life can lay an unstable foundation for mental health that endures well into the adult years. [234]

Infants do better if they are cared for in a safe, warm and responsive way. This supports their healthy development and enables them to acquire the basic skills of emotional regulation and social communication. It also helps them to learn more easily, develop better social relationships and be less likely to engage in risk behaviours throughout their lives.

NICE has developed Pathways bringing together all NICE guidance, quality standards and other NICE information on NICE Pathways for ypoung people with personality disorder. The guidance notes that NHS trusts providing CAMHS should ensure that young people with severe borderline personality disorder have access to tier 4 specialist services if required.[235]

Recommendations for Commissioners:

- Review the availability across Kent of universal parenting support programmes for parents of children 0-5, 5-10 and 10-16. Unsupportive and unstimulating parenting has been linked with some intellectual disabilities and conduct disorders.
- In particular, it is important to ensure that screening is linked to appropriate support and intervention and is carried out in a supportive and sensitive manner to avoid a sense of parents being or feeling stigmatised, for example because of their own mental health problems.
- Review the availability of evidenced based interventions for children with conduct problems aged younger than 12 years and their families in priority communities.
- Care of young people in transition between children and adult services with conduct and related disorders should have their transition planned and managed according to the best practice guidance described in the developing NICE Guidance.[236]
    - Health and social care services should refer vulnerable young people with a history of conduct disorder or contact with youth offending schemes, or those who have been receiving interventions for conduct and related disorders, to appropriate adult services for continuing assessment and/ or treatment.
    - NHS trusts providing CAMHS should ensure that young people with severe borderline personality disorder have access to tier 4 specialist services if required,[237] which may include:
        - inpatient treatment tailored to the needs of young people with borderline personality disorder
        - specialist outpatient programmes
        - home treatment teams
    - CAMHS and adult healthcare professionals should work collaboratively to minimise any potential negative effect of transferring young people from CAMHS to adult services. They should time the transfer to suit the young person, even if it takes place after they have reached the age of 18 years and continue treatment in CAMHS beyond 18 years if there is a realistic possibility that this may avoid the need for referral to adult mental health services.[238]

Support for Parents:

- Focus on identifying and supporting vulnerable parents, where appropriate antenatally, including:

  - Parents with other mental health problems or with significant drug or alcohol problems.
  - Mothers younger than 18 years, particularly those with a history of maltreatment in childhood.
  - Parents with a history of residential care.
  - Parents with significant previous or current contact with the criminal justice system.
  - Parents in a domestic abuse context.

- When identifying vulnerable parents, care should be taken not to intensify any stigma associated with the intervention or increase the child's problems by labelling them as antisocial or problematic.
- Additional interventions targeted specifically at the parents of children with conduct problems (such as interventions for parental, marital or interpersonal problems) should not be provided routinely alongside parent training programmes, as they are unlikely to have an impact on the child's conduct problems.

4.6 Treatment of Personality Disorder in Adults

In adults the development of effective treatments for people diagnosed with personality disorders was given a boost in 2003, with the publication by the Department of Health of a directive entitled *Personality Disorder: No Longer a Diagnosis of Exclusion*.[239] This document offered guidance for health services to develop multidisciplinary specialist PD treatment teams, whose task would be to develop ways of working with service users diagnosed with PD.[240] These specialist teams could be informed by evidence of what service users, clinicians and academics consider important for people diagnosed with PD; namely that services should aim to reduce the stigma associated with the diagnosis, provide a range of psychological and psychosocial interventions to help people improve their coping skills, social functioning and quality of life, and provide support for accessing education and employment.[241] Psychological intervention contributes to this menu of options and the national “Improved Access To Psychological Therapies” programme is developing support for people with PD.

By definition, personality disorders are associated with a significant burden on the individuals with the disorder, those around them and on society in general. Early research noted that fewer individuals with a personality disorder make contact with psychiatric services compared with those with other conditions such as schizophrenia and depression[242] and their probability of withdrawing from treatment is considerably higher [243]. We now know more about the general distribution and prevalence of these disorders, the factors

that influence their course and outcome, and their impact on new and existing mental health services, as well as on other services. As can be seen from the data explored in Chapter 3 there are significant deprivation factors driving personality disorders and, in line with earlier research, [244] there is a greater prevalence in deprived urban areas.

General adult mental health services in England and Wales offer varying levels of service provision for people with PD since the decision was made in 2003 to expand services to include the treatment of personality disorders. Although these services are for PD generally, most users seeking services are likely to have a diagnosis of BPD and this is the case in Kent and reflects the service provision.[245] There is a potential problem in service planning this way for both adults, children and their families with regard to need; we must consider how to support children and adults suffering from PD who do not seek help.

Recommendation: Services are normally restricted to symptomatic, help seeking individuals; Aa vulnerable group with cluster persoanility disorders can be identified early, are in care during childhood and enter the criminal justice system when young[246]. There is a need for further review of preventive interventions to support carers, children and adults at the public mental health level.

4.7 NICE Guidance

4.7.1 Treatment, Management and Prevention of PD

NICEQuality Standard 88 Personality disorders: borderline and antisocial [247] draws on existing borderline and ASPD set out below guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Quality standard 88 covers treatment and management of borderline and antisocial personality disorders. For borderline personality disorder, this quality standard applies to adults aged 18 and over and young people post puberty. For antisocial personality disorder, this quality standard applies only to adults aged 18 and over. NICE quality standard 59 covers antisocial behaviour and conduct disorder in children and young people under 18 years. [248]

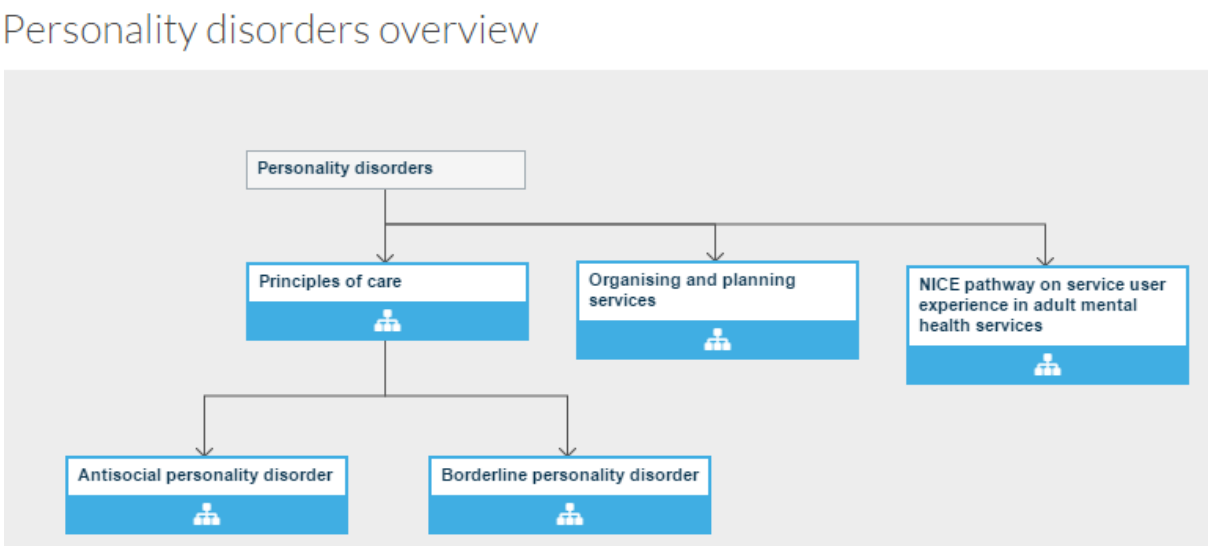
NICE guidance for the treatment, management and prevention of ASPD in primary, secondary and forensic healthcare.[249] The guideline is concerned with the treatment of people with ASPD across a wide range of services including those provided within mental health services (including substance misuse), social care and the criminal justice system. NICE draws on the best available evidence; however, it notes there are significant limitations to the evidence base, notably a relatively small number of randomised controlled trials (RCTs) of interventions with few outcomes in common.

There is NICE guidance for BPD that is relevant to adults and young people for the recognition and management of the condition, and recent research findings have contributed to an improved understanding and treatment of the disorder.[250] BPD is characterised by severe functional impairments, a high risk of suicide, a negative effect on the course of depressive disorders, extensive use of treatment, and high costs to society. The course of this disorder is less stable than expected for personality disorders. The causes are not yet clear, but genetic factors and adverse life events seem to interact to lead to the disorder. There is a strong association between insecure attachment in early adulthood and borderline personality disorder symptoms. [251] This formulation overlaps with the importance of the "invalidating" family environment suggested by Linehan as a factor in the genesis of borderline personality disorder.[252]

Although the prognosis of BPD is relatively good, with most people not meeting the criteria for diagnosis after 5 years, it is important to note that a minority of people have persistent symptoms until late in life.[253]

NICE has published the personality disorder pathway for the management of BPD and ASPD by community services:

Figure 30: NICE Personality Disorder Pathway Overview[254]



Source: NICE: http://pathways.nice.org.uk/pathways/personality-isorders

The NICE Personality disorder pathway sets out general principles:

Ensure that people with antisocial or borderline personality disorder from black and minority ethnic groups have equal access to culturally appropriate services based on clinical need.

When language is a barrier to accessing or engaging with services for people with antisocial or borderline personality disorder, provide them with:

- Information in their preferred language and in an accessible format.
- Psychological or other interventions in their preferred language.
- Independent interpreters.

Autonomy and choice:

Work in partnership with people with antisocial or borderline personality disorder to develop their autonomy and promote choice by:

- Ensuring that they remain actively involved in finding solutions to their problems, including during crises.
- Encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make.[255]

All services are expected to tackle the stigma associated with mental health services and comply with the *Service User Experience in Adult Mental Health Services* NICE quality standard.[256]

4.7.2 Pharmacological Treatment

No drug has UK marketing authorisation for the treatment of BPD or ASPD. In its ASPD guidance NICE recommends more research and argues 'there is little evidence in the literature on the pharmacotherapy of antisocial personality disorder to justify the use of any particular medication. However, multiple drugs in various combinations are used in this group either to control aberrant behaviour or in the hope that something might work. Current interventions lack a clear rationale'.[257]

The use of antidepressants, mood stabilisers and antipsychotics is common in clinical practice as pharmacological treatments are often prescribed based on target symptoms shown by the individual, with chemicals often prescribed to help regulate emotions.[258] A longitudinal study found that 75% of participants with BPD were prescribed combinations of drugs at some point,[259] and research into the care of people with BPD indicates that many people are taking several classes of psychotropic drug simultaneously.[260]

Psychotropic drugs have clinically significant side effects ranging from weight gain, diabetes and cardiovascular disease to problems with self esteem,[261] with the balance of risk and benefit more unfavourable in young people due to treatment-emergent suicidal ideation.[262]

The treatment for PD is challenging and national guidance suggests that drug treatment should not be used specifically for PD, although the use of medication has increased.[263]

4.7.3 Psychological Treatment for BPD

Specific forms of psychotherapy seem to be beneficial for at least some of the problems frequently reported in patients with BPD. At present, there is no evidence to suggest that one specific form of psychotherapy is more effective than another.[264] However Lineham and colleagues work with Dialectical Behavior Therapy (DBT), a cognitive behavioural treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD), is arguably the "gold standard" psychological treatment for this population (see below).[265]

Psychotherapy is usually the first treatment for people with BPD. Current research suggests psychotherapy can relieve some symptoms, but further studies are needed to better understand how well psychotherapy works. It is important that people in therapy get along with and trust their therapist. The very nature of BPD can make it difficult for people with this disorder to maintain this type of bond with their therapist.

Therapy can be provided one on one between the therapist and the patient or in a group setting. Therapist led group sessions may help teach people with BPD how to interact with others and how to express themselves effectively.

Systems Training for Emotional Predictability and Problem Solving (STEPPS) is one type of group therapy designed as a relatively brief treatment consisting of twenty two hour sessions led by an experienced social worker. Scientists funded by National Institute for Mental Health reported that STEPPS, when used with other types of treatment (medications or individual psychotherapy), can help reduce symptoms and problem behaviours of BPD, relieve symptoms of depression, and improve quality of life. The effectiveness of this type of therapy has not been extensively studied.[266]

Dialectical Behaviour Therapy (DBT). Over the last 15 years, DBT has been developed specifically to treat BPD with indications of positive effects, particularly for self harming.[267] This type of therapy focuses on the concept of mindfulness, or being aware of and attentive to the current situation. DBT teaches skills to control intense emotions, reduces self-destructive behaviours, and improves relationships. DBT is a broad-based cognitive behavioural treatment originally developed for chronically suicidal individuals diagnosed with BPD. Consisting of a combination of individual psychotherapy, group skills training, telephone coaching, and a therapist consultation team, DBT was the first psychotherapy shown through controlled trials to be effective with BPD. [268] The fundamental dialectic in this therapy is between validation and acceptance of the patients as they are, within the context of simultaneously helping them to change.[269] The components of standard outpatient dialectical behaviour therapy are once weekly individual psychotherapy, co-ordinated with a weekly skills training group and telephone consultations between sessions with the primary therapist with the aim of preventing emergencies by providing skills coaching and/or relationship repair with the therapist. The fourth component is a weekly consultation session for the therapy team members to ensure adherence to the model and

to keep them motivated in the face of the difficulties that arise in the treatment of individuals with borderline personality disorder.

DBT therapy can help reduce suicidal behaviours in people with BPD. For example, one study showed that DBT reduced suicide attempts in women by half compared with other types of psychotherapy and talk therapy. [270] DBT also reduced use of urgent care and inpatient services and retained more participants in therapy, compared to other approaches to treatment.[271]

Data also suggest considerable flexibility and malleability of BPD traits in youth, making this a key developmental period during which to intervene. Early intervention programmes have shown that BPD in young people responds to intervention.[272]

Cognitive Behavioural Therapy (CBT). CBT can help people with BPD identify and change core beliefs and/or behaviours that underlie inaccurate perceptions of themselves and others, and problems interacting with others. CBT may help reduce a range of mood and anxiety symptoms and reduce the number of suicidal or self harming behaviours.[273]

Schema-Focused Therapy. This type of therapy combines elements of CBT with other forms of psychotherapy that focus on reframing schemas, or the ways that people view themselves. This approach is based on the idea that BPD stems from a dysfunctional self-image, possibly brought on by negative childhood experiences, that affects how people react to their environment, interact with others, and cope with problems or stress.[274]

Families of people with BPD may also benefit from therapy. The challenges of dealing with an ill relative on a daily basis can be very stressful and family members may unknowingly act in ways that worsen their relative's symptoms.[275]

Some therapies, such as DBT Family Skills Training (DBT-FST), include family members in treatment sessions. These types of programs help families develop skills to better understand and support a relative with BPD. Other therapies, such as Family Connections, focus on the needs of family members. More research is needed to determine the effectiveness of family therapy in BPD. Studies with other mental disorders suggest that including family members can help in a person's treatment.

Other types of therapy may be helpful for some people with BPD. Therapists often adapt psychotherapy to better meet a person's needs. Therapists may switch from one type of therapy to another, mix techniques from different therapies, or use a combination therapy.

Some symptoms of BPD may come and go, but the core symptoms of highly changeable moods, intense anger, and impulsiveness tend to be more persistent. People whose symptoms improve may continue to face issues related to co-occurring disorders, such as depression or post traumatic stress disorder. Encouraging research suggests, however, that

relapse, or the recurrence of full blown symptoms after remission is rare. In one study, 6% of people with BPD had a relapse after remission.

4.7.4 Psychological Treatment for ASPD

NICE notes there has been little formal development of psychological interventions specifically for the treatment of ASPD.[276] Considerably more emphasis has been placed on the psychological treatment of other personality disorders, primarily BPD.[277] Developments in cognitive behavioural treatments have emerged but such approaches in ASPD are not supported by a strong evidence base.[278]

Psychological interventions for comorbid disorders are, by contrast, well developed and are as effective or more effective than pharmacological treatments for common mental disorders.[279] This suggests that such interventions may have a significant role to play in the treatment of comorbid disorders in ASPD. Similarly effective psychological treatments for drug and alcohol disorders have also been developed and may again be of benefit to people with ASPD with comorbid drug and alcohol problems.[280]

4.7.5 Research into Improving Access to Psychological Therapies (IAPT) for Severe Mental Illness

In 2008 the Department of Health launched the Improving Access to Psychological Therapies Programme (IAPT) to help increase public access to a range of psychological treatments for depression and anxiety that have been recommended by the National Institute for Health and Clinical Excellence (NICE). The IAPT programme's long term aim is to ensure that all people with a psychosis, bipolar and personality disorder, who could benefit from evidence based therapies, have access to them. To support this ambition the IAPT programme has set up the Severe Mental Illness (SMI) Project.

The competence framework describes the method for identifying competences for staff in IAPT services working with people with PD.[281] It identifies the "therapeutic stance, values and assumptions" for work in these areas.

There are six national demonstration sites for IAPT for people with a personality disorder. This involves working with NHS England alongside two other mental health trusts in central London to improve access to evidenced based psychological interventions. As learning develops, this needs assessment will be updated.

4.7.6 Services in Kent for Personality Disorder

Adult psychological and psychosocial interventions in Kent are commissioned by clinical commissioning groups (CCGs) from Kent and Medway Mental Health Partnership Trust (KMPT) in a variety of ways and settings within the NHS by clinical psychologists, psychiatrists, nurses, social workers and other mental health therapists. There are dedicated CCG mental health commissioning teams across Kent.

4.7.6.1 Primary Care Services

A team of primary care mental health workers is available across Kent to improve care available for people with PD who have been discharged from community mental health services or whose GP has identified that they would benefit from this service.

Improving Access to Psychological Therapies (IAPT) services are commissioned by CCGs and are available through primary care or self referral across Kent and it is not known how many people with PD are currently accessing these services for comorbidities, who are not accessing secondary care services. This Needs Assessment will be updated when the national Improving Access to Psychological Therapies for Severe Mental Illness (IAPT for SMI) pilot project reports on whether it has been successful at increasing public access to NICE approved psychological therapies for PD. The long term ambition of the IAPT for SMI project is to ensure that evidence based psychological therapies are routinely available as a frontline treatment of all people with SMIs, including PD, who could benefit from them.[282]

4.7.6.2 Secondary Care Services: KMPT Brenchley Unit (Personality Disorder Service)

The Brenchley Unit is at the core of the West Kent Personality Disorder Service. It offers a three day a week therapeutic community for people diagnosed with a severe or borderline personality disorder. The unit offers support and understanding and service users are encouraged to talk freely about their difficulties.

Within this developing communication, patients can come to trust and be trusted; to learn more about themselves and about others. Members need to have a degree of insight into their problems and have some motivation to change themselves and their lives; there is a waiting list for this service.

KMPT Outreach Service

The outreach programme offers members up to two years of psychotherapy. KMPT recognises that the outreach service represents a vital service provision in its own right for many patients who for one reason or another are not available for the full programme and, in some cases, is sufficient therapy. For others it gives a good grounding in preparation for joining the full programme.

Treatment Philosophy for KMPT's Day Therapeutic Community

The service aims to treat people with longstanding psychological and emotional problems and a history of multiple service use. Many of the people referred to the service have a long history of repeated brief crisis interventions and/or lengthy periods of admission to inpatient services within general psychiatry.

Referrals

All referrals come from Adult Mental Health services.

4.7.7 KMPT Ash Eton Community (The Personality Disorder Service)

The centre point of the East Kent Personality Disorder Service is the Ash Eton Therapeutic Community in Folkestone, a one year group-based therapy programme for up to 24 members at any one time. The Ash Eton Community is a community facility housed at Ash Eton, a large Edwardian building close to the Royal Victoria Hospital.

On community days, the Ash Eton Community has the use of three group rooms including a large community and art studio space and a good sized kitchen and dining room with an adjoining lounge area. Some rooms overlook the park and effort has been made to try to make the setting more comfortable and less institutional than can often be the case with NHS settings.

There is a four week introductory group, 1.5 hours per week, to help orientate potential members to the programme. This is an opportunity for initial introductions and to start to focus on what each member would like to gain from therapy.

Therapies include talking therapy, art therapy, a writing group, studio time and the leavers' group.

More research is also needed on the diagnosis, neurobiology, and treatment of personality disorder. Kent CCGs are in the process of recruitment to support mental health commissioning and in East Kent this will focus on East Kent wide mental health services development, specifically the PD service. The South Kent Coast operational plan seeks to improve the current PD provision for the benefit of more patients with PD and to improve acute liaison psychiatry services with KMPT.[283]

In summary, interventions during childhood and adolescence are increasingly shown to be effective and cost efficient. There is some debates among specialists whether services should continue to focus on a small group of symptomatic, help seeking individuals with treatment seeking disorders [284]or on the larger, currently more "hidden" population we have identified with multiple social impairments, those leaving social services and institutional care for children, and those presenting in adulthood to criminal justice instead of healthcare agencies.

5.0 Summary and Conclusions

Personality disorders are characterised by severe functional impairments, a high risk of suicide, a negative effect on the course of depressive disorders, extensive use of treatment, and high costs to society.

It is estimated that 36% of 5-10 year olds looked after by local authorities had clinically significant conduct disorders compared to 5% of children this age living in private households.

In 2014, there are an estimated 5,438 people aged 16-74 with personality disorder in Kent and a total of 2,448 admissions related to personality disorder in adults aged 16-74 years.

5.1 Adverse circumstances drive child conduct disorders and adult personality disorders

Foundation for personality disorders are laid in the early years and childhood. Early years conduct disorders in children often precede adult presentation with personality disorder and in particular anti-social behaviour disorder. The 1999 ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three to fourfold increase in prevalence in social classes D and E compared with social class A. In Kent there is a very significant linear relationship between the prevalence of personality disorder and deprivation; the greater the deprivation the higher the prevalence of personality disorder.

There remains a need to intervene early to identify and support parents and children with conduct disorders through targeted interventions including evidenced based parenting. The earlier the interventions the better the outcomes for the child.

5.2 Children looked after are particularly vulnerable

Of 5-10 year olds looked after by local authorities, 36% had clinically significant conduct disorders compared to 5% of children this age living in private households. In the age group 11-15, 40% of looked after children were diagnosed with conduct disorders compared to 6% in private households.[285] There is a strong link between conduct disorders in childhood and adult antisocial behaviour disorder. NICE draws on the best available evidence; it notes, however, that there are significant limitations to the evidence base for the treatment of antisocial behaviour disorder, notably a relatively small number of randomised controlled trials (RCTs) of interventions with few outcomes in common.

There is stronger both NICE guidance for BPD that is relevant to adults and young people for the recognition and management of the condition, and recent research findings have contributed to an improved understanding and treatment of the disorder.[286] The course of this disorder is less stable than expected for personality disorders. The causes are not yet clear, but genetic factors and adverse life events seem to interact to lead to the disorder.

There is a strong association between insecure attachment in early adulthood and borderline personality disorder symptoms. [287] This formulation overlaps with the importance of the "invalidating" family environment suggested by Linehan[288] as a factor in the genesis of borderline personality disorder.

The high incidence of conduct and personality disorder in those who have been in local authority or institutional care, particularly in the cluster B group, and their subsequent criminal convictions, suggest that robust preventive and treatment strategies for this population could have a major influence on public health.

5.3 Care and treatment of Adult Personality Disorder

Interventions during childhood and adolescence are increasingly shown to be effective and cost efficient. The debate in the literature is still on whether services should continue to focus on a small group of symptomatic, help seeking individuals with treatment seeking disorders or on the larger, currently more "hidden" population we have identified with multiple social impairments, those leaving social services and institutional care for children, and those presenting in adulthood to social care and criminal justice instead of healthcare agencies.

Personality disorder behaviours are longstanding characteristics noticeable from early childhood or early teens. These behaviours can make it hard to control feelings, can hinder coping strategies, make it difficult to sustain relationships, cause difficulty in interpreting social cues and can cause distress to the individual and/or to others. Borderline personality disorder (BPD) is the most common and is present in just under 1% of the population. BPD is the most common diagnosis of PD in Kent and the majority of those diagnosed are women. In Kent 90% of people diagnosed with ASPD are male. Men diagnosed with antisocial behaviour disorder account for a disproportionately large proportion of crime and violence committed.

Evidence for the treatment of PD in adult life is growing. However the evidence base for factors that should be considered when deciding the type and intensity of care that people receive are poorly understood. People with PD present in a fragmented way across public services and prison healthcare making continuity of care a challenge.[289, 290] Commissioners and providers may wish to work together in order to establish a more responsive model of care for this challenged community that offers continuity of care.

There is no direct medical test to diagnose PD, and difficulties with diagnosis are compounded by the amount of information needed on personal history in order to assess personality traits. In Kent there also appear to be high numbers of admissions coded as "personality disorder of type? unknown". This is complex situation. Diagnosis can only be made by specialist clinician and/or psychiatrist. The sensitivity and specificity of screening tools are poor and the research proves this.[291]

Due to the numbers of people who are estimated to have PD in the county, in both the general and criminal justice populations, and the diagnostic challenges, there is likely to be a significant unmet need and there is also potential for misdiagnosis.

National research suggest men suffer BPD at the same rate as women but are not present in services at an equal rate. Consideration needs to be given to this gender imbalance and the problem in service planning with regard to need; we must consider how to support children and adults suffering from PD who do not seek help. Services appear to be restricted to symptomatic, help seeking individuals, early reseach noted a vulnerable group with cluster B disorders that can be identified early, are in care during childhood and enter the criminal justice system when young. This is the case in Kent where significant numbers of looked after children have conduct disorders and suggests the need for a review of preventive interventions to support looked after children at the public mental health level as a priority.[292] The high incidence of personality disorder in those who have been in local authority or institutional care, particularly in the cluster B group, and their subsequent criminal convictions, suggest that preventive and treatment strategies in this population could have a major influence on public health. Currently much less attention is given to the involvement of these individuals in treatment programmes as evidenced by the lack of research available.

Table 15: Expected Number of BPD Cases In Adults Aged 16-74 in Kent, East Sussex, South East Region and England & Wales by Age Group and Gender, 2014.[293], [294]

	Estimated Number of Men with BPD				Estimated Number of Women with BPD			
Age	**16-34**	**35-54**	**55-74**	**16-74**	**16-34**	**35-54**	**55-74**	**16-74**
Kent	515	400	658	1608	2406	1031		3861
East Sussex	158	135	292	580	726	360		1377
South East	3119	2431	3897	9689	14288	6221		22673
England & Wales	22479	15890	25311	65297	102959	40462		152420

Source: Adult Psychiatric Morbidity in England survey (2007
Office for National Statistics Mid-Year Resident Population Estimates

Split by gender, females are 2.4 times more likely to be diagnosed with BPD than males; with an estimated 3,861 females and 1,608 males aged 16-74 expected to have BPD.

Annex 1 National Policies and Guidance

Managing Dangerous People with Severe Personality Disorder, Proposals for Development (1999)[295] This Home Office paper discusses existing models, services and approaches, and sets out the lack of treatment available for those people with severe PD who present a danger to the public.

Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services For People With Personality Disorder (2003)[296] The National Institute for Mental Health in England (NIMHE) produced policy implementation guidance for the development of services for people with PD. This document confirmed that PD services should be part of the core business of mental health trusts and suggested that specialist multidisciplinary PD teams should be established for people with PD in significant distress, with difficulties or complex needs and the development of specialist day patient services in areas with high morbidity from PD.

Breaking the Cycle of Rejection: Personality Disorder Capabilities Framework (2005).[297] This document, produced by NIMHE set out a framework to support the development of skills enabling more effective working between practitioners and people with personality disorders and to support local and regional partners to deliver appropriate education and training. In conjunction with the 2003 guidance this has led to an NHS commitment to enhance and improve its service for PD.

The Bradley Report (2009)[298] A six month independent review of the extent offenders with mental health problems or learning disabilities could be diverted from prison and what barriers prevented this. This review highlights the need for early identification of people with mental health problems or learning difficulties entering the criminal justice system. Custody may exacerbate mental illness and may not be the right environment for such people. There is potential for appropriate and timely intervention.

Borderline personality disorder: The NICE guidance on treatment and management (2009)[299] This guidance is based on best practice and systematic reviews of the best available evidence.[300]

The main guidelines are:

- Psychological treatment, especially for people with multiple comorbidities or severe impairment (or both) should include an explicit and integrated theoretical approach, structured care in accordance with this guideline and supervision by a therapist. Twice weekly sessions should be considered or this should be adapted to the persons need.
- Long term psychological interventions should be used for BPD (over three months in duration).
- Drug treatment should not be used specifically for BPD.
- People with BPD should not be excluded from any other health or social care service.

- It is important to build a trusting relationship and work in an open, engaging and nonjudgemental manner: people would often have experienced rejection, abuse and trauma.
- Care should be person centred and people with BPD should have the opportunity to make informed decisions along with their healthcare professional about their care and treatment.
- Professionals should work in partnership and actively involve people with BPD in finding solutions, encouraging consideration of different treatments or life choices and considering consequences of their choices.
- Any changes should be discussed with the person (and their family and carers if appropriate) beforehand and should be structured and phased as any change may elicit strong emotions.
- Care plans should support work with other care providers during endings, referrals and transitions and crisis service provision should be available.
- Community Mental Health (CMH) services should be responsible for routine assessment, treatment, and management.
- CMH teams should develop comprehensive multidisciplinary care plans with service users which should be shared with their GP. They should identify roles and responsibilities for service providers and user, and develop short term treatment aims, long term goals and a crisis plan.
- Mental Health Trusts should develop crossdiscipline specialist PD services with expertise in diagnosis and management of BPD: These services should provide consultation and advice to primary and secondary care, provide assessment and treatment for people with complex needs, offer expert diagnostic services to general psychiatric services, ensure clear communication within and between services, work with Child and Adolescent Mental Health Services to develop transitions to adult services, oversee implementation of NICE guidance, develop training programmes for diagnosis, treatment and management, and monitor service provision.

The Offender Personality Disorder Strategy (2011)[301]

Key Principles are that:

- The personality disordered offender population is a shared responsibility of (National Offender Management Service (NOMS) and the NHS.
- Planning and delivery is a whole systems pathway approach across the criminal justice system and the NHS from conviction, sentence, and community based supervision and resettlement.
- Offenders with PD at high risk of serious harm to others are primarily managed through the criminal justice system.
- Treatment and management is psychologically informed and led by psychologically trained staff; that it focusing on relationships and the social context in which people live.
- Related Department of Education and Department of Health programmes for young people and families will continue to be joined up with the offender PD pathway to contribute to prevention. As noted earlier in this needs assessment it is important to note that research into the evidence for community-based interventions to enhance quality of life in children of SMI (seriously mentally ill) parents is lacking. The capacity to recommend evidence-based

approaches is limited. Rigorous development work is needed to establish feasible and acceptable child- and family-based interventions, prior to evaluating clinical effectiveness and cost-effectiveness.[302]

- Experiences and perceptions of offenders and staff should inform service design and delivery.
- Pathways will be evaluated focusing on risk of serious re-offending, health improvement and economic benefit.

Antisocial Behaviour and Conduct Disorders in Children and Young People Recognition, Intervention and Management National Clinical Guideline Number 158 National Collaborating Centre for Mental Health and Social Care Institute for Excellence commissioned by the National Institute for Health and Care Excellence.[303] This guideline, published by The British Psychological Society and The Royal College of Psychiatrists, is a collaboration between NICE and the Social Care Institute for Excellence (SCIE), and has been developed to advise on the recognition, identification and management of conduct disorders (including oppositional defiant disorder) and associated antisocial behaviour in children and young people. It is intended that the guideline will be useful to clinicians and service commissioners in providing and planning high-quality care for people with conduct disorders and antisocial behaviour while also emphasising the importance of the experience of care for people with conduct disorders and their carers.

Standards for Prison Mental Health Services Quality Network for Prison Mental Health Services 2015.[304] The standards in this document address areas which are key to prison mental healthcare, and by participating in the quality network, teams will have the opportunity to measure their performance against these best practice standards through a model of openness and engagement. The quality network will provide a framework to support prison mental health teams to improve quality through self and peer review process and will also facilitate and encourage teams from different services across the country to share good practice and learn from each other.

From these guides and policies an offender PD pathway is being implemented, with new arrangements for the assessment, management and treatment of offenders in prison and the community. Services are primarily targeted at men who present a high risk of serious harm to others and women who present a high risk of committing further violent, sexual or serious criminal damage offences. Offenders are likely to have a severe PD/complex needs, and a clinically justifiable link between the disorder and the offending. A key principle for the offender's pathway is that it is psychologically informed, and focuses on relationships and the social context in which people live. NHS England and NOMS have plans for a credible, effective and robust longitudinal evaluation of the national OPD pathway to demonstrate the impact of the approach and assess whether it is effective and provides good value for money.[305]

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