7.4 Personality Disorders

Personality disorder is significant in terms of prevalence, morbidity and the extensive use of services by those who sometimes exhibit the most chaotic and disturbed behaviour.

There is established evidence that personality disorders can be effectively managed, increasing the person's quality of life and decreasing use of health and criminal justice services, however to date there have been insufficient services provided in Northern Ireland.

People with a personality disorder and their carers are least likely to be satisfied with traditional provision of care and the Bamford Review of Mental Health services recommended the development of dedicated personality disorder services in both the reports on forensic services and adult mental health services.

People with personality disorders are already heavy users of health, social care and criminal justice services, however in the absence of dedicated provision may not receive optimal management. Approximately 10 % of people with personality disorder eventually commit suicide and 12% of all people who commit suicide have a diagnosis of personality disorder. Middle aged women with borderline personality disorder commit suicide as commonly as young males.

Overarching Standard 49: Personality disorder – assessment, early intervention, treatment and ongoing care

A person presenting with clinically problematic personality disorder should have a comprehensive mental health assessment including an assessment of risk by mental health specialist using an appropriate assessment tool and be referred for specialist personality disorder assessment, if required. They should have access to a range of appropriate treatments and care according to their individual needs and access to education, advice, support and management delivered by a specialist, regional personality disorder service as appropriate.

Rationale

Early assessment and engagement with appropriate services will reduce an inappropriate use of other services.
To ensure quality, consistency, co-ordination and accountability of care.
Supports treatment models and addresses a gap in current services.
Appropriate treatment and care delivered to meet individual need can help to manage interpersonal functioning, cognition, mood and impulsivity.

Evidence

DOH (2003) Personality Disorder – No Longer a Diagnosis of Exclusion
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4054230.pdf

National Coordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) report (2007) Learning the Lessons: A multi-method evaluation of dedicated community-based services for people with personality disorder
http://www.sdo.nihr.ac.uk/files/project/83-final-report.pdf

Home Office and Department of Health England (2006) Personality Disorder Capacity Plans 2005
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4139095.pdf

National Institute for Health and Clinical Excellence (NICE) (2009) Antisocial Personality Disorder: treatment, management and prevention
http://guidance.nice.org.uk/CG77

National Institute for Health and Clinical Excellence (NICE) (2009) Borderline Personality Disorder: treatment and management
http://guidance.nice.org.uk/CG78

NI Personality Disorder Group

DHSSPS (2010) Personality Disorder: A Diagnosis for Inclusion – The Northern Ireland Personality Disorder Strategy
http://www.dhsspsni.gov.uk/northern-ireland-personality-disorder-strategy-june-

2010.pdf

Responsibility for Delivery

Commissioners
Trusts
Specialist Personality Disorder Service
Criminal Justice System
Primary, Secondary and Recovery Mental Health Services
Other Statutory, Voluntary and Community Groups.

Quality Dimension

Person Centred - People, what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for them given their unique context and lifestyle.
Effective – Evidence has shown that appropriate and timely interventions can improve outcomes and reduce adversity.
User and Carer – Centred. Considers the needs of the individual and his/her carer/family.
Equitable – Promotes social inclusion regardless of age and inequity.
Safe – any person presenting either as a risk to themselves or others should be referred and assessed by specialist mental health specialists immediately

Performance Indicators	**Data Source**	**Anticipated Performance Level**	**Date to be achieved by**
Quality of Life Indicators. Social Performance Indicators – to be determined	Evaluation of treatment and service delivery model. Health economics evaluation.	Establish baseline Performance levels to be determined once baseline established	March 2013