Development of Services for Treatment of Personality Disorder in Adult Mental Health Services

Position Paper

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Summary

People diagnosed with personality disorders have enduring difficulties in their ways of thinking, feeling, and behaving that cause serious disruption to their ability to function in society and usually significant degrees of distress. Historically people with personality disorders have been stigmatised and treated at the margins of health services, often ineffectually. Despite great advances in the treatment of personality disorders internationally, Ireland remains markedly under-served with effective treatment options.

The purpose of this position paper is to:

1 Identify the prevalence and level of unmet need of personality disorders in Ireland with a focus on adult mental health services
2 Review the scientific evidence on treatments for personality disorders and international treatment guidelines and treatment guidelines
3 Establish the current level of service provision for personality disorder in Ireland
4 Make recommendations to the Health Service Executive and College of Psychiatrists of Ireland for the further development of personality disorder treatment in Ireland

Key findings and recommendations

People with personality disorders experience significant morbidity and mortality. Despite the existence of well-established evidence-based treatments these are not widely available within Ireland.

We recommend:

- A national strategy for the treatment of personality disorders in Ireland
- The establishment of evidence-based treatment services
- Development of expertise in the treatment of personality disorders

Executive Summary

Purpose of paper

Over the last few decades there has been significant progress in the development of effective treatments for people with personality disorders, particularly emotionally unstable (borderline) personality disorder. In other countries this has led to the transformation of services provided to this patient group. However, in Ireland there continues to be no national strategy for the treatment of personality disorders.

In this paper we aim to describe the wide prevalence of difficulties that could be described as personality disorders within the population of Ireland and to highlight the significant level of suffering and wider impact on society that this entails. Our particular focus is on adult mental health services.

We review the current scientific evidence on treatments available for people with personality disorders and compare these with the national treatment guidelines from other comparable countries to Ireland. We also report the results of a survey of psychiatrists attempting to capture what services are currently provided for personality disorders within Ireland.

Finally, we make recommendations for the further development of personality disorder treatment in Ireland.

Target audience

The College of Psychiatrists of Ireland and the wider community of psychiatrists working within Ireland as leaders in the provision of mental health care within the state. The Health Service Executive and policy makers more widely as those responsible for the development and provision of mental health services in Ireland.

Key findings

Personality disorder can be defined as a significant impairment in self and interpersonal functioning that is pervasive and inflexible and differs significantly from that expected within the wider population. It usually has an onset in adolescence or early adulthood and up to half of those attending adult mental health services may meet the criteria for a personality disorder diagnosis. People with personality disorders experience significant morbidity and mortality.

Despite this prevalence, services for people with personality disorders are poorly developed in Ireland, hampered by a lack of resources and specialist training. However, there are well established and evidence-based treatments that have been developed for people with personality disorders, largely longer-term psychotherapeutic interventions.

In the absence of these specialist treatments, people with a primary diagnosis of personality disorder often present in a crisis and tend to be treated at the margins of services, through emergency departments or unplanned hospital admissions. Attitudes of those they meet can be negative, both in the health system more generally but also within mental health services themselves and clinicians

often feel unskilled to help these patients with a reliance on inappropriate and ineffective treatments such as medication.
In Ireland, there is currently no national programme to plan or deliver structured services for those with personality disorder that seek treatment. There is also no training structure within the College of Psychiatrists of Ireland to identify and direct specialist training so that psychiatrists can acquire expertise to treat personality disorders and there is no recognised psychiatric specialty of medical psychotherapy to provide leadership in this regard.

Key recommendations

Therefore, we recommend that the Health Service Executive (HSE) develops a national strategy to provide evidence-based services for the treatment of people with personality disorders accompanied by the funding to deliver these services. We also recommend that the College of Psychiatrists of Ireland advocates for and develops training in the diagnosis and treatment of personality disorders for psychiatrists. Finally, we wish to highlight the crucial position that the psychiatric specialty of medical psychotherapy can occupy in transforming the provision of services for people with personality disorders.

Introduction

A definition of personality disorder is given by The World Health Organisation (1992) in their Classification of Mental and Behavioural Disorders:

These types of condition comprise deeply engrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in the giving culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance.

Although there are many different ways of classifying personality disorders, one of the most frequently encountered subcategories seen by mental health services is that of borderline (also known as emotionally unstable) personality disorder and it is this group of people that has been most closely studied in relation to mental health services.

People with a diagnosis of personality disorder have high levels of health service utilisation including emergency presentations, self-harm and suicidal behaviours, as well as comorbid addiction, depression, and anxiety disorders. In addition to marked mental and social morbidity people with diagnoses of personality disorder have significantly reduced life expectancy (almost twenty years) compared to the general population [1] with lifetime suicide rates for borderline personality disorder of around 10% [2].

The economic burden of personality disorder includes direct and indirect costs to the health service and other non-health related costs and patients with a diagnosis of personality disorder have a greater demand for criminal justice and social care services and reduced economic productivity.

It is difficult to get an accurate estimate of the prevalence of personality disorders due to differing methodologies and sample populations and there is very little data available for the Irish population. It is estimated that a diagnosis of borderline personality disorder features in up to 20% of clinical presentations to mental health outpatient clinics in Ireland [3]. One Irish study conducted in Waterford looked at the diagnosis of personality disorders in patients attending outpatient and inpatient services and found rates of nearly 40% with any diagnosable personality disorder and around 10% with borderline personality disorder [4].
An older study found a quarter of new admissions to two Dublin psychiatric hospitals had a personality disorder [5] while a prevalence study among young adults (19-24yrs) in Dublin found that around 3% had one of a subset of personality disorders (antisocial, borderline, schizotypal, schizoid and paranoid) with 1.5% having borderline personality disorder [6]. In survivors of institutional abuse in Ireland rates were as high as 30% experiencing one of a subset of personality disorders (antisocial, borderline, avoidant and dependent) [7]. There is an abundance of research on the role of childhood trauma in the development of borderline personality [8] and also evidence for an intergenerational aspect, with mothers diagnosed with personality disorder, borderline personality in particular, experiencing significant difficulties with parenting [9] with their children vulnerable to higher rates of psychiatric disorders [10] including borderline personality itself [11]. Unfortunately, at the present time, there are no specialist parent-infant interventions available in the Irish health service.

While community prevalence rates for personality disorders are not available for the Irish population as a whole rates for Great Britain have been estimated at 4.4% with 0.7% with borderline personality [12] and other international estimates range from 4-15% [13].

Personality disorders are commonly comorbid with other psychiatric disorders and comorbidity with chronic physical health disorders is also common. Among primary care attenders rates of personality disorders have been estimated at around one quarter with around half of psychiatric outpatients meeting criteria for personality disorders. The highest rates of personality disorders have been found in the criminal justice system with two thirds or more of prisoners having a personality disorder [13].

There has been little economic analysis of mental health interventions in Ireland but a 2018 study estimated the direct cost to the Irish health service to manage on individual with borderline personality disorder to be over €10k per year which could represent a total annual cost of at least €300 million [14] while an international review of evidence-based psychological interventions for people with borderline personality has estimated saving of around $3k per patient per year [15].

The 2006 document 'A Vision for Change' [3] has driven Irish mental health policy for a decade. It makes specific recommendations about the need for evidence-based interventions for the treatment of borderline personality disorder to be delivered by local mental health services and for specialised therapeutic expertise to be developed for those with more severe and complex difficulties. It specifically mentions dialectical behaviour therapy (DBT) and this has been promoted in Ireland through the National Office for Suicide Prevention which has provided central resources for training existing mental health staff in DBT. The new mental health policy for Ireland, 'Sharing the Vision', was launched in 2020, this makes no mention of services for people with personality disorders, not even in the section on suicide prevention, somewhat undermining its subtitle of 'A Mental Health Policy for Everyone' [16].

The situation in Ireland can be contrasted with our nearest neighbour where the publication of the English guidance 'Personality disorder: No longer a diagnosis of exclusion' in 2003 [17] marked a turning point in personality disorder provision within the National Health Service (NHS), outlining a blueprint for the development of future service delivery that was followed-up by eleven pilot projects that demonstrated benefits from many different models of care provision [18]. Since 'No longer a diagnosis of exclusion' was published various reports, policies, strategies, and frameworks focusing on personality disorders have followed, focusing on all the constituent parts of the United Kingdom [19] [20] [21].

Historically people with personality disorder have been marginalised by society and by mental health services and in Ireland this continues into the present day. It is very disappointing that Ireland currently has no national strategy for developing services to help people with personality disorder and, in many ways, recent developments represent a step backwards.

This paper aims to identify the pressing need for the development of services for people with diagnoses of, or difficulties consistent with personality disorder, and to make recommendations as to how these could be developed in adult mental health services in Ireland. Adults attending Mental Health of Intellectual Disability services, Forensic Mental Health services, or whose care is primarily within the criminal justice system are outside the scope of this review. The diagnosis and treatment of personality difficulties in those aged under eighteen years are also not considered within this review. This means that any measures that could be considered to potentially prevent the emergence of personality disorder are beyond the scope of the review.

Diagnosis and categorisation

Historically personality disorders have been divided into various specific diagnoses depending on the pattern of symptoms and these are often grouped into three broad categories:

- Cluster A- 'odd or eccentric' types (paranoid, schizoid, schizotypal)
- Cluster B – 'dramatic, emotional or erratic' types (borderline or emotionally unstable, histrionic, narcissistic, antisocial)
- Cluster C – 'anxious and fearful' types (obsessive/compulsive, dependent, avoidant)

While cluster C diagnoses are most common it is generally considered that cluster B diagnoses, particularly borderline personality disorder and antisocial personality disorder cause the greatest demand on mental health, wider health and social care, and criminal justice services.

However, it has long been recognised that this approach of discrete and separate personality disorder diagnoses has significant shortcomings, not least because of our dimensional understanding of personality more broadly and the overlap between categories and unreliability of drawing distinctions between different personality disorder diagnoses [22]. There has been a drive for many years towards a dimensional approach to diagnosis that views personality as a continuum with normal variation at one end of the spectrum and severe personality disorder at the other [23].

This has been reflected in the new ICD-11, coming into effect in 2022 to replace ICD-10, which uses a dimensional approach to classify personality disorder. It focuses on a global level of severity of personality difficulties which ranges from: "Personality Difficulty", through "Mild Personality

Disorder" and "Moderate Personality Disorder" to "Severe Personality Disorder". It focuses on the level of impairment of self and interpersonal functioning. There is an option to specify the presence of one or more prominent trait qualifiers: Negative Affectivity; Detachment; Dissociality; Disinhibition; Anankastia. The clinician can also specify an additional Borderline Pattern qualifier.

Conversely, the DSM-5, used primarily in the US, has retained the categorical approach adopted in the preceding DSM-IV with paranoid, schizoid, schizotypal, narcissistic, antisocial, borderline, obsessive-compulsive, dependent and avoidant diagnoses. It does include an "alternative model for personality disorders" which adopts a hybrid approach to generate dimensional scores for various trait facets which are then used to determine whether criteria for six specific personality disorders are met (antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, schizotypal).

While there are structured clinical interviews (such as the SCID-II interview) that can be used to diagnose personality disorders, and which are considered 'gold standard' in clinical research, there remains some controversy as to whether these are necessary to make an accurate or reliable diagnosis of personality disorder.

Treatment

Specialised psychotherapy

For many years patients with personality disorder were considered to be untreatable and clinicians would therefore often avoid making the diagnosis at all. We now know that there are a number of different psychotherapeutic interventions which are effective for treating people with personality disorder, most specifically borderline personality disorder. However, the patchy and insufficient provision of such services in Ireland may also discourage clinicians from making a diagnosis for which they can offer no effective treatment.

A recent systematic review by the Cochrane Collaboration has brought together extensive findings from 75 RCTs (4507 participants) looking at trials of sixteen different types of psychological therapies [24]. The main findings are outlined below:

- *Specialised psychotherapy versus usual treatment*

  Psychotherapy significantly reduced borderline personality disorder symptom severity compared with treatment as usual. There was a significant reduction in self-harm, suicide-related outcomes were reduced and psychosocial functioning improved significantly. Psychotherapy also significantly reduced depression.

- *Individual treatment approaches*

  Dialectical behaviour therapy (DBT) demonstrated significant effects on borderline personality severity, self-harm and psychosocial functioning.

  Mentalisation-based treatment (MBT) was found to have a significant effect on self-harm and suicidality.

The reviewers stated that they found no unequivocal, high-quality evidence to support one specific therapy for borderline personality disorder over another although they noted the specific findings for DBT and MBT above. However, the main therapies studied were highly structured and longer term treatments, many with a mixture of group and individual work which could be delivered by multidisciplinary teams with training and supervision, and it is likely that these characteristics are necessary for an effective treatment programme.

Medication

While the use of medication in people with personality disorders is widespread, there is no convincing evidence that any particular medication is effective in treatment and no single drug to date has been approved for such use in Europe or the United States. The prevalence of medication may be more reflective of lack of access to effective psychotherapy than any intrinsic efficacy.

There is some literature suggesting that medication can have some benefit on certain subdomains of symptoms in personality disorders but not on the core difficulties and all studies have been short in duration. Clinical experience and expert consensus is that medication has only a limited role to play in personality disorders and usually only in the context of acute crisis when short-term sedating agents can be considered as adjuvants to non-pharmacological interventions. A decision to prescribe must be balanced and anticipate overall impact in care plan and future treatment strategies [25].

International treatment guidelines

Some of the most influential international clinical guidelines are those published by the National Institute for Health and Care Excellence (NICE) for the English National Health Service (NHS). The NICE clinical guidelines for borderline personality disorder [25] identify the importance that patients with borderline personality disorder are not excluded from services and a collaborative approach that emphasises patient autonomy and choice, optimism, and building a trusting relationship. The difficulties of endings and transitions between services are highlighted. NICE recommends that secondary mental health services (namely community mental health services and child and adolescent mental health services) should be responsible for the diagnosis and treatment of personality disorders using multidisciplinary care planning, but that for people with more severe difficulties specialist multidisciplinary personality disorder services should be developed for both assessment and treatment as well as providing consultation and training to other services.

In terms of psychological treatment NICE recommends that there is an 'explicit and integrated theoretical approach' used by both the treatment team and the therapist, along with therapist supervision and structured care. Brief psychotherapy of less than three months is discouraged outside of such a service.

For women with recurrent self-harm a 'comprehensive' dialectical behaviour therapy (DBT) programme is suggested but NICE do not make any further specific recommendations about individual psychotherapeutic approaches to borderline personality disorder due to lack of evidence. They do explicitly mention DBT and mentalisation-based treatment (MBT) and also some other therapies for people with less severe symptoms. They do not recommend medication for treating borderline personality disorder (unless treating comorbid mental disorders) but it is suggested that sedative medication can be used in the short-term during crisis.

The NICE guidelines on antisocial personality disorder [26] reflect many of those in the guideline for borderline personality disorder including developing optimistic and trusting relationships, but in terms of psychological interventions the only recommendation is for people with antisocial personality disorder and a history of offending for group-based cognitive and behavioural interventions (e.g. programmes such as 'reasoning and rehabilitation') focused on problems such as impulsivity, interpersonal difficulties, and reducing offending and other antisocial behaviour. The use of medication for the treatment of antisocial personality disorder is discouraged due to the lack of evidence of any benefit. The multi-agency nature of working with people with antisocial personality disorder is emphasised, particularly the role of forensic mental health services, the criminal justice system, and drug and alcohol services.

Considering personality disorder guidelines from across Europe, the US, and Australia [27] [28] [29] they focus almost exclusively on borderline personality disorder and recommend outpatient psychotherapy as the first line intervention but specific psychotherapeutic modalities (e.g. DBT) are not usually recommended. While most guidelines recommend avoiding medication a minority suggest that it can be used to target specific symptom dimensions.

Current state of personality service provision in Ireland

As there is no centrally administered register of personality disorder service provision in Ireland the Personality Disorder Special Interest Group of the College of Psychiatrists of Ireland conducted a survey in 2019 to identify what current services are offered in adult mental health services for the treatment of personality disorders. This indicated that, while there has been some progress in delivering services for people with personality disorders as outlined in 'Vision for Change', there is significant scope for further development.

Results

We received 114 responses from consultants in both the public and private sector. 57% of respondents stated that they had an evidence based treatment in their service while, in contrast, 9% of respondents were unaware of any specific service.

The main treatment modality offered was dialectical behaviour therapy (DBT) followed by cognitive behaviour therapy (CBT), psychodynamic psychotherapy, cognitive analytic therapy (CAT), schema focused, and mentalization based treatment (MBT).

Nearly half of respondents identified lack of resources as the main obstacle to delivering a service where none was currently available.

Training and professional development

The College of Psychiatrists of Ireland (CPsychI) was formed in 2009 as the professional body for psychiatrists in the Republic of Ireland. The Mission of the College of Psychiatrists of Ireland is to promote excellence in the practice of psychiatry. Historically, training and experience in psychotherapeutic approaches and in the diagnosis, management, and treatment of personality disorders has been lacking, internationally and in Ireland in particular. The college is now responsible for the training of psychiatrists in Ireland and while the postgraduate training curriculum includes

outcomes relating to the assessment of personality disorders it has not yet developed any specific training targeted at either upskilling existing consultant psychiatrists or helping trainees to develop the necessary and specific competencies needed to effectively treat people with personality disorders. The foundation of the college offers an opportunity to radically overhaul professional training in the area of personality disorders in Ireland. Unlike other jurisdictions, Ireland also lacks consultant psychiatrists with a recognised specialism in medical psychotherapy, and it is often these psychiatrists who lead specialist personality disorder services.

Recommendations

For the Health Service Executive

- To implement the recommendations from 'Vision for Change' to provide both localised and specialist services for the treatment of people with personality disorders, these should be evidence based to ensure that what is offered is cost effective and helpful to patients – this approach could be incorporated into the new 'Model of Care for adults accessing Talking Therapies while attending specialist mental health services' which adopts a similar hub and spoke structure
- To develop specialist personality disorder services to foster the expertise and experience in psychiatric and other clinical staff that is necessary to lead further training and service development on a national level as well as to cater to the most complex and severe patients
- To fund the establishment of specialist consultant medical psychotherapist posts to provide the expertise and leadership necessary to manage specialist personality disorder services
- To commission a National Clinical Programme for personality disorders to further develop the provision of services within Ireland
- To provide new and adequate funding to implement both the minimum necessary services outlined in 'Vision for Change' throughout Ireland and to further develop services through a National Clinical Programme
- To ensure the expectation that services for people with personality disorders will be offered throughout the country and not just in a few locations or pilot sites
- To develop a wider educational programme about personality disorders, perhaps modelled on the Knowledge and Understanding Framework (KUF) training in England, to widen knowledge and awareness of personality disorder within the health service more broadly and also associated agencies such as social care and the criminal justice system
- To establish a mechanism or body to include the patient voice in developing future service provision and training, addressing the historical marginalisation of people with personality disorders

For the College of Psychiatrists of Ireland

- To develop training in the diagnosis, management, and treatment of personality disorders for both trainees and existing consultant psychiatrists
- To advocate for the central role of the consultant psychiatrist in the management of personality disorders, and in particular to develop new training pathways for consultant medical psychotherapists in Ireland (and mechanisms for their retrospective recognition) in order to provide the leadership and expertise necessary to drive the transformation of services provided to people with personality disorders

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References

[1] M. Lei-Yee Fok, R. Hayes, C. Chang, R. Stewart, F. Callard and P. Moran, "Life expectancy at birth and all-cause mortality among people with personality disorder," Journal of Psychosomatic Research, vol. 73, no. 2, pp. 104-107, 2012.

[2] J. Paris and H. Zweig-Frank, "A 27-Year Follow-up of Patients with Borderline Personality Disorder," Comprehensive Psychiatry, vol. 42, no. 6, pp. 482-487, 2001.

[3] Department of Health, "A Vision for Change: Report of the Expert Group on Mental Health Policy," The Stationary Office, Dublin, 2006.

[4] A. Carr, M. Keenleyside, M. Fitzhenry, D. W. M. Harte, K. O'Hanrahan, J. Hayes, P. Cahill, H. Noonan, H. O'Shea, A. McCullagh, S. McGuinness, C. Rodgers, N. Whelan, N. Sheppard and S. Browne, "Personality disorders in an Irish mental health service: the Waterford Mental Health Survey," The Irish Journal of Psychology, vol. 36, no. 1-4, pp. 3-11, 2015.

[5] J. Cooney, C. Farren and A. Clare, "Personality disorder among first ever admissions to an Irish public and private hospital," Irish Journal of Psychological Medicine, vol. 13, no. 1, pp. 6-8, 1996.

[6] M. Harley, D. Connor, M. Clarke, I. Kelleher, H. Coughlan, F. Lynch, C. Fitzpatrick and M. Cannon, "Prevalence of Mental Disorder among young adults in Ireland: a population based study," Irish Journal of Psychological Medicine, vol. 32, pp. 79-91, 2015.

[7] A. Carr, B. Dooley, M. Fitzpatrick, E. Flanagan, R. Flanagan-Howard, K. Tierney, M. White, M. Daly and J. Egan, "Adult adjustment of survivors of institutional child abuse in Ireland," Child Abuse & Neglect, vol. 34, no. 7, pp. 477-489, 2010.

[8] M. Zanarini and F. R. Frankenburg, "Pathways to the development of borderline personalioty disorder," Journal of Personality Disorders, vol. 11, pp. 93-104, 1997.

[9] K. Steele, M. Townsend and B. Grenyer, "Parenting and personality disorder: An overview and meta-synthesis of systematic reviews," PLoS One, vol. 14, no. 10, p. e0223038, 2019.

[10] S. Conroy, C. Pariante, M. Marks, H. Davies, S. Farrelly, R. Schacht and P. Moran, "Maternal psychopathology and infant development at 18 months: the impact of maternal personality disorder and depression," Journal of the American Academy of Child & Adolescent Psychiatry, vol. 51, no. 1, pp. 51-61, 2012.

[11] C. White, J. Gunderson, M. Zanarini and J. Hudson, "Family Studies of Borderline Personality Disorder: A Review," Harvard Review of Psychiatry, vol. 11, no. 1, pp. 8-19, 2003.

[12] N. Singleton, R. Bumpstead, M. O'Brien, A. Lee and H. Meltzer, "Psychiatric morbidity among adults living in private households, 2000," International Review of Psychiatry, vol. 15, pp. 65-73, 2003.

[13] P. Tyrer, G. Reed and C. MJ, "Classification, assessment, prevalence, and effect of personality disorder," The Lancet, vol. 385, no. 9969, pp. 717-726, 2015.

[14] J. Bourke, A. Murphy, D. Flynn, M. Kells, M. Joyce and J. Hurley, "Borderline personality disorder: resource utilisation costs in Ireland," Irish Journal of Psychological Medicine, vol. 30, pp. 1-8, 2018.

[15] D. Meuldijk, A. McCarthy, M. Bourke and G. BFS, "The value of psychological treatment for borderline personality disorder: Systematic review and cost offset analysis of economic evaluations," PLoS One, vol. 12, no. 3, pp. 1-19, 2017.

[16] Department of Health, "Sharing the Vision: A Mental Health Policy for Everyone," 2020.

[17] National Institute for Mental Health in England, "Personality disorder: No longer a diagnosis of exclusion," 2003.

[18] L. Wilson and R. Haigh, "INNOVATION IN ACTION: Review of the Effectiveness of Centrally Commissioned Community Personality Disorder Services," 2011.

[19] National Public Health Service for Wales, "Meeting the Health Social Care & Wellbeing Needs of Individuals with a Personality Disorder," 2005.

[20] Department of Health Northern Ireland, "PERSONALITY DISORDER: A DIAGNOSIS FOR INCLUSION THE NORTHERN IRELAND PERSONALITY DISORDER STRATEGY," 2010.

[21] Royal College of Psychiatrists, "Personality disorder in Scotland: raising awareness, raising expectations, raising hope," 2018.

[22] L. Clark, "Assessment and Diagnosis of Personality Disorder: Perennial Issues and an Emerging Reconceptualization," Annual Review of Psychology, vol. 58, pp. 227-57, 2007.

[23] P. Tyrer, "Diagnostic and Statistical Manual of Mental Disorders: A classification of personality disorders that has had its day," Clinical Psychology & Psychotherapy, vol. 19, no. 5, pp. 372-374, 2012.

[24] O. Storebø, J. Stoffers-Winterling, B. Völlm, M. Kongerslev, J. Mattivi, M. Jørgensen, E. Faltinsen, A. Todorovac, C. Sales, H. Callesen, K. Lieb and E. Simonsen, "Psychological therapies for people with borderline personality disorder," Cochrane Database of Systematic Reviews, p. Issue 5: CD012955, 2020.

[25] National Institute for Health and Care Excellence, "Borderline personality disorder: recognition and management," 2009.

[26] National Institute for Health and Clinical Excellence, "Antisocial personality disorder: prevention and management," 2013.

[27] S. Sebastian, A. Bateman, M. Bohus, H. Jan Dalewijk, S. Doering, A. Kaera, P. Moran, B. Renneberg, J. Ribaudi, S. Taubner, T. Wilberg and L. Mehlum, "European guidelines for personality disorders: past, present and future," Borderline Personality Disorder and Emotion Dysregulation, vol. 6, p. 9, 2019.

[28] National Health and Medical Research Council, "Clinical Practice Guideline for the management of Borderline Personality Disorder," 2012.

[29] American Psychiatric Association, "PRACTICE GUIDELINE FOR THE TREATMENT OF BORDERLINE PERSONALITY DISORDER," 2001.

[30] National Institute for Health and Clinical Excellence, "Personality disorders: borderline and antisocial," 2015.

[31] National Institute for Health and Care Excellence, "Self-harm in over 8s: short-term management and prevention of recurrence," 2004.

[32] Royal College of Psychiatrists, "Services for people diagnosable with personality disorder," 2020.