Written evidence submitted by the Talking Therapies Task Force (TTTF) (MHB18)

People diagnosed with severe and complex Personality Disorder detained under the Mental Health Act. Implications for the new Mental Health Bill

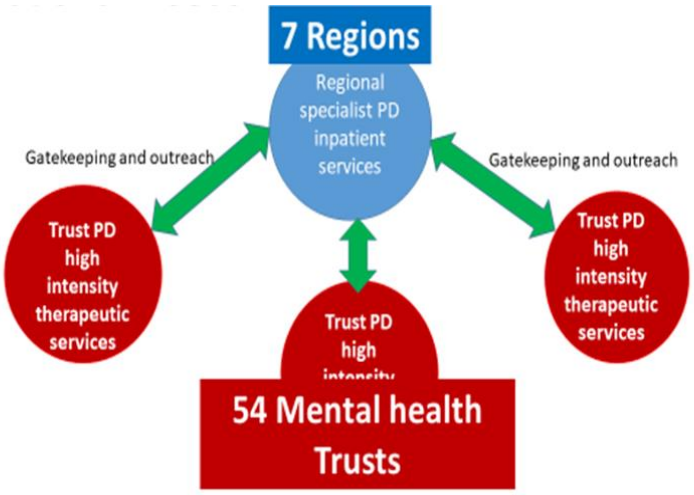
Background

The HEARD[1] study published in the recent CMH report (Improving support for people with complex mental health difficulties (2025)) identified a small proportion of all people diagnosed with Personality Disorder and related co-morbidities who experience extended stays in hospital predominantly in mental health services. Based on this study of almost 30,000 patients in two Trusts, it is estimated 10,000 people diagnosed with personality disorder in the UK are long term inpatients. The majority of these are likely to be detained under the Mental Health Act (MHA). Government figures indicate in 2023 to 2024 there were around 52,500 new detentions under the MHA. Based on the CMH report findings it is likely that about one in five of those detained have a diagnosis of Personality Disorder. This corresponds with other estimates of the prevalence of Personality Disorder in inpatient settings (Evans et al (2017) and Moran et al (2002).

The HEARD study highlighted the transdiagnostic presentations of this group of hospitalised patients, the extent to which they have been overlooked in Health and Social Care strategy and the consequent absence of appropriate therapeutic treatment pathways for this group. The study also presented robust evidence that such therapeutic pathways, tailored to the needs of high risk hospitalised patients with transdiagnostic symptoms, both improve clinical outcomes and reduce cost. The CMH report recommended the development of a national programme of specialist therapeutic pathways for this hospitalised group. The pathways would have a smaller number of regional specialist inpatient beds provided closer to home than the existing out of area placements. These inpatient services would be linked to high intensity therapeutic services in the community offered as an alternative to or step down from hospital in each Trust. The majority of patients currently hospitalised could be managed in the community with intensive psychotherapeutic programmes. A small minority (perhaps 10% or 1000 patients) would need to start their psychotherapeutic journey in a psychotherapeutic inpatient setting because their difficulties are of a nature and severity that could not be managed in community settings (Figure 1).

[1] Health Economics And Relational Disorder

Figure 1



Some examples might help to clarify which clinical presentations are likely to require inpatient therapeutic work before moving to therapy in a less restricted setting in the community:

- Patients with the most highly impulsive and dangerous suicidal and self-harming behaviour (evidenced by multiple, repeated 'near miss' suicide attempts).
- Patients with severe restricting eating disorders with a BMI of below 14 or other high risk indicators (rapid weight loss or physical health risks exacerbated by other health conditions e.g. diabetes) who self-harm severely on gaining weight.
- Patients with personality disorder with functional disorders (functional weakness, non-epileptic seizures, akinetic mutism) alongside the presentations above where their physical disability complicates the management of their other high risk behaviour.
- Any of the presentations listed so far, further complicated by substance misuse and autistic spectrum disorder.

Patients with these difficulties won't accept admission informally either because they only want to die or because they lack insight into the seriousness of their condition. They are highly likely to require detention under the Mental Health Act.

Controversy about using the MHA for people with a diagnosis of Personality Disorder

There is some controversy amongst mental health professionals about the merits of admitting people with a diagnosis of Personality Disorder to hospital or detaining them under the MHA. Unlike other psychiatric disorders such as Schizophrenia or Bipolar disorder to which the MHA applies, Personality Disorders are by definition relational. They are disorders of relating to self and other which most often originate in disordered or traumatic relating as part of childhood adversity, the early pattern of disordered relating being carried into adulthood. This includes the pattern of relating to health professionals. Mental health professionals undertaking MHA assessments with people with a diagnosis of Personality Disorder who are aware of this are often caught between detaining a person for their safety, repeating early experiences of

coercive control or not detaining them, with consequent threat to life, repeating early experiences of abandonment. The most common concerns expressed by mental health professionals at MHA assessment with people diagnosed with Personality Disorder are:

- Although the purpose of admission is to reduce risk, admission can increase risk in some cases by removing the patient's responsibility for their own safety.
- 'Treatment' for personality disorder is not available in acute MH wards, medication may relieve symptoms but does not treat the disorder and MH wards are not designed as therapeutic environments.
- NICE guidance for people with Borderline Personality Disorder (2009) recommends admissions should be avoided where possible. When necessary admissions should be brief.
- People with this diagnosis are considered to have mental capacity to make their own decision about whether to live or die.

These concerns highlight some problems in using the MHA appropriately for people with a diagnosis of Personality Disorder in services as they are currently configured.

1. Avoiding admission where possible and minimising the dangers of iatrogenic harm arising from admission or detention under the MHA is a useful rule of thumb for people with less severe personality disorder. The appropriate pathway of care is through psychotherapeutic services with Complex Emotional Needs in the community.
2. Hospital admission most often under the MHA cannot be avoided without loss of life or serious damage to physical health for those with the most severe and complex Personality Disorder. For these patients the management of risk is seriously impacted by the lack of training in understanding and managing these patients in inpatient settings in nursing and medical training. Because evidence based psychotherapeutic pathways for this group have not yet been developed, admission for treatment is not yet available in circumstances in which patients are very unwell and at risk of death. This makes appropriate decision making difficult for those undertaking MHA assessment. Finally the assumption that people with this diagnosis have mental capacity in making decisions relating to their physical and mental health seldom holds true for those with severe and complex PD. Most commonly their impulsivity or lack of insight impair their ability to weigh the decision in question. Training in assessing mental capacity in people with severe and complex personality disorder is required.

Recommendations for consideration at the committee stage of the Mental Health Bill.

1. That reference is made to the specific difficulties in assessing people with a diagnosis of Personality Disorder in the new Code of Practice.
2. That reference is made to the transdiagnostic presentations of people with the most complex Personality Disorder in which risks may arise from self-harm / risk of completed suicide, eating disorders or physical health complications arising from

somatic presentations of co-morbid physical health conditions. Assessment of risk and decision making about detention should be made on the basis of a holistic assessment not on the basis that a diagnosis of Personality Disorder is part their presentation.

3. Given that one of the stated aims of the Bill is to reduce the number of detentions and it is estimated that 20% of detentions are of people with a diagnosis of Personality Disorder, consideration of the amendments at the committee stage provides an opportunity to:
    - Review the training of mental health professionals which should routinely include training in the relational containment and management of risk of people with this diagnosis in inpatient settings.
    - Training in the assessment of mental capacity in people diagnosed with severe and complex Personality Disorder
    - The development of specialist therapeutic pathways for people with the most severe and complex PD so that the amended act can be used appropriately for this patient group.

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On behalf of the Talking Therapies Task Force[2].

References

Evans, S., Sethi, F., Dale, O., Stanton, C., Sedgwick, R., Doran, M., Shoolbred, L., Goldsack, S., & Haigh, R. (2017). Personality disorder service provision: A review of the recent literature. Mental Health Review Journal, 22(2), 65–82. https://doi.org/10. 1108/MHRJ-03-2016-0006

Moran, P. (2002), "*The epidemiology of personality disorders*", available at: http://webarchive.nationalarchives.gov.uk/20130107105354/; www.dh.gov.uk/assetRoot/04/13/08/45/04130845.pdf (accessed 17 November 2014).

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[2] The Association for Psychoanalytic Psychotherapy in the Public Sector, The British Association for Counselling and Psychotherapy, The British Psychoanalytic Council, The Royal College of Psychiatrists, The Society for Psychotherapy Research (UK Chapter), The United Kingdom Council for Psychotherapy,