Personality Disorder: no longer a diagnosis of exclusion?

Law, policy and practice in Scotland

Abstract

Personality disorder has been and continues to be a contested diagnosis. Those who attract this form of diagnosis have been particularly vulnerable to the effects of stigma and have tended to be excluded from service provision. This thesis provides an examination of how recent developments in law, policy and practice have impacted upon the status of personality disorder as a diagnosis of exclusion in Scotland. The theoretical framework that provides this thesis with its structure is derived from the post-empiricist approach proposed by Derek Layder. This approach seeks to contextualise emergent inductive findings within a broader historical and contemporary analysis. In the case of this research the broader context consists of the interplay between mental health law, policy and practice in the field of mental health and the diagnosis of personality disorder more specifically.

The empirical enquiry at the core of this thesis is based upon an analysis of the views, beliefs and expectations of front-line staff (psychiatrists and social workers qualified as mental health officers) involved in the process of assessment and service provision. In addition to front-line staff (n = 27) a range of key informants who were in a position to shed light on the strategic imperatives underpinning recent developments in law and policy were also interviewed. This analysis is contextualised within a review of key developments in law and policy that have particular significance for anyone who may attract a diagnosis of personality disorder.

Despite the ostensibly inclusive approach towards those who may attract a diagnosis of personality disorder evident within the Mental Health (Care and Treatment) (Scotland) Act 2003, the reality is a highly selective and very limited inclusion of those who attract this form of diagnosis. The effective inclusion of those who may attract a diagnosis of personality disorder has been obstructed by several key impediments: 1: an insufficiently robust policy framework to drive forward the process of inclusion; 2: residual ambivalence towards the legitimacy of the diagnosis of personality disorder itself and the legitimacy of the claims made upon services by those who may attract a diagnosis of personality disorder; 3: insufficient and inadequately focused resources; 4: service structures that have not been redesigned sufficiently to engage successfully with service users who may attract a diagnosis of personality disorder. As a consequence of these impediments to inclusion, the majority of those who may attract a diagnosis of personality disorder in Scotland are likely to continue to face high levels of marginalisation and exclusion.

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Chapter 1:

Introduction to Thesis

This thesis is based on an empirical enquiry into key developments concerning personality disorder in Scotland following the inclusion of this form of diagnosis as a category of mental disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003. How the diagnosis of personality disorder is understood and the way that the needs of those who attract this diagnosis are provided for is of fundamental importance to all those who are given this label. The diagnosis of personality disorder is distinct from other forms of medical diagnosis, not least because it is a diagnosis of who the person is, rather than being something that a person has. In this respect the diagnosis of personality disorder, arguably more than any other form of medical diagnosis, tends to define how the person is seen and how others relate to them (Stalker, Ferguson et al. 2005).

Research Questions

The process of enquiry underpinning this thesis seeks to address the following five questions:

1. In what ways does the inclusion of personality disorder within mental health law in Scotland reflect an acknowledgement of the legitimate needs and rights of service users?

2. How does the inclusion of personality disorder within mental health law fit into a broader range of strategies of control and regulation characteristic of an advanced liberal democracy?

3. How has the inclusion of personality disorder influenced the way that those who attract this diagnosis are perceived and responded to by front-line workers?

4. In what ways has current legislation influenced the availability of services for those who attract a diagnosis of personality disorder?

5. In what ways has current legislation influenced the ability of those who attract a diagnosis of personality disorder to access appropriate services?

The empirical enquiry at the heart of this thesis involves interviews with key informants from the domains of policy and practice. The process of enquiry and analysis used throughout the conduct of this research has been iterative and reflexive. The methodological approach within which this process of enquiry and analysis has been conducted is based upon the adaptive model proposed by Derek Layder (1982).

The rationale for conducting this enquiry stems from my own experiences as a social work practitioner during the 1990s and early part of the new millennium. In keeping with many other practitioners, I observed that those who were designated as having a personality disorder were

routinely excluded from service provision. This was typically because a diagnosis of personality disorder often involves a dual diagnosis, an ambiguity that frequently allowed service providers to claim that a potential service user was not eligible but should instead be referred to an alternative service. Among the most common examples of this form of exclusion was that of service users being redirected back and forth between mental health and substance misuse services; or alternatively on the basis that the nature of the diagnosed disorder meant that the potential service user would frequently be regarded as untreatable.

Personality disorder includes a range of specific disorders, as detailed within the International Disease Classification of Mental and Behavioural Disorders (World Health Organisation 1992) and the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2000). Throughout this thesis, when reference is made to personality disorder, this should be taken to refer to a range of diagnoses rather than a singular diagnosis. The diagnosis of personality disorder has always been and remains contested. Debate continues as to whether personality disorder should be accorded a legitimate place within medicine and psychiatry more specifically. Those who criticise the inclusion of personality disorder within the classification of psychiatric disorders commonly base their objections on the grounds that personality disorder represents a particular form of social disapproval masquerading as a medical diagnosis.

In order to understand the origins of the concept of personality disorder, it is necessary to contextualise this within the broader origins and development of psychiatry itself. Psychiatry emerged as a specific branch of medicine to provide a means of classifying and categorising abnormality as part of a broader system of regulation and control (Foucault 1965) in an attempt to impose a rational order upon the seemingly irrational. According to Foucault this should be understood as part of a broader set of concerns following the Enlightenment with its characteristic emphasis upon rationality, whereby madness and irrationality more generally became objects of fear. Psychiatry carved out a specific sphere of influence within which "...the abnormal individual and the domain of abnormalities (became) the privileged object of psychiatry" (Foucault 2003:323). Given that the classification of abnormality and normality are substantially informed by normative judgements (Foucault 2003), the basis of all psychiatric classifications and diagnoses can be contested, a fact which has significant implications for the drafting and implementation of law and policy (Pilgrim 2005).

The extent to which personality disorder if it can be regarded as a legitimate diagnosis at all, is treatable and if so what form that treatment should take, also continues to be deeply contested. One of the defining characteristics of personality disorder sets it apart from other forms of diagnosis within biomedicine, namely that the diagnosis is inferred from behaviours that are taken as evidence of the underlying disorder. Reaching a diagnosis of personality disorder therefore rests upon a fundamentally tautological process.

Personality disorder has been widely acknowledged as historically constituting a barrier to those who are so labelled accessing services; the effect has all too frequently been that those who attracted a diagnosis of personality disorder became routinely excluded from services and as a consequence were often left vulnerable, marginalised and isolated (Ferguson, Barclay et al. 2003). Famously those who attract this form of diagnosis have been described as 'the patients that psychiatrists love to dislike' (Lewis and Appleby 1988).

Personality disorder was explicitly included within mental health law in Scotland for the first time in emergency legislation rushed through the newly established Scottish Parliament in 1999 in the form of the (Mental Health (Public Safety and Appeals) (Scotland) Act 1999). The rationale offered by the Scottish Executive was that there was a clear and immediate risk to public safety based upon a flaw within the existing mental health legislation. The explicit inclusion of personality disorder in mental health law in Scotland was therefore driven by concerns centring upon perceptions of dangerousness and risk, rather than due to an acknowledgement of the right of those who may be given this diagnosis to be included within the sphere of service provision. Subsequently the publicly stated policy within Scotland was one of inclusion ostensibly intended to challenge the status of personality disorder as a diagnosis of exclusion; however whether those who attract a diagnosis of personality disorder are able to successfully access services, depends critically upon practice 'on the ground' in the context of the actual policy framework that shapes the way services are designed and delivered: the relationship

between practice and policy therefore forms a central part of the enquiry at the heart of this thesis.

During the late 1990s personality disorder became the subject of a particularly contentious debate concerning dangerousness and the merits of preventive detention. Within this context, predicated on the concept of Dangerous and Severe Personality Disorder (DSPD), the UK Government announced its intention to legislate in order to introduce preventive detention for those deemed to fall within this new category. In an attempt to develop a greater understanding of this development, the author of this thesis undertook an MA in Social Policy and Criminology, the focus of which specifically concerned these proposals and their implications for those who might fall within this new category. The specific enquiry presented within this thesis was informed by this earlier research. The specific research presented within this thesis was prompted by key developments in mental health law in Scotland namely: the enactment of emergency legislation in the form of the (Mental Health (Public Safety and Appeals) (Scotland) Act 1999), which was also the first legislative act of the newly devolved parliament, and the subsequent Mental Health (Care and Treatment) (Scotland) Act 2003 that replaced the Mental Health (Scotland) Act 1984.

The initial focus of the research reported here was the practical impact of the decision to explicitly retain personality disorder within the 2003 Act. During the course of conducting the literature review however, another equally fundamental issue began to emerge and became central to the

empirical enquiry, analysis, findings and conclusions reported within this thesis. The specific issue that became problematic for the author concerned the rationale for the explicit inclusion of personality disorder within mental health law in Scotland. The problem revolved around two alternative possibilities namely: 1) that the rationale for the explicit inclusion of the diagnosis of personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003, was based on the recognition of the historical injustices done to those who had become marginalised and excluded as a consequence of having been given a diagnosis of personality disorder; 2) that the inclusion of personality disorder represents an expansion of the 'carceral archipelago' (Foucault 1991) and should be understood more broadly in terms of the rationality of neoliberal approaches to regulation and control and a preoccupation with the management and containment of risk. From this perspective the psy-disciplines play a crucial role in identifying those individuals who can be governed within "the open circuits of community control" (Rose 1999:261), and those who cannot be managed in this way thereby necessitating the management of their behaviours within more closed circuits of control such as "psychiatric institutions (to provide for) the secure containment of risk" (Rose 1999:261).

The tensions evident within the process of formulating mental health legislation and policy can also be understood in terms of the broader analysis of welfare provision provided by Offe (1982) as serving the role of ameliorating the worst effects of capitalism, while at the same time serving the fundamental objective of ensuring that a sufficient supply of

labour is available. This same theme has been developed more recently by Pilgrim (2012) and will be considered subsequently in the analysis of findings. The relevance of the latter point will be given specific consideration in the analysis of the development of the policy framework for mental health and personality disorder more specifically.

The structure of the thesis

This thesis begins with a literature review that is presented in three chapters. Together these chapters provide an overview as well as a more detailed analysis of the origins and development of personality disorder and psychiatric diagnostic classifications more generally.

Chapter 2 contextualises personality disorder in terms of psychiatric taxonomies, alternative theoretical explanations for what has come to be classified as personality disorder and how the diagnosis of personality disorder frequently results in a despoiling of the individual to produce a residual 'spoiled identity' (Goffman 1963).

Chapter 3 contains an historical and comparative analysis of how the law relating to personality disorder has developed and changed in the jurisdictions of Scotland and England / Wales. This chapter is used to explore many of the contentious issues concerning how personality disorder should be framed within the policy and law, most notably

concerning whether it should be given any explicit acknowledgement at all and if so, in what form.

Chapter 4 concerns more recent developments in Scotland and provides the context for the analysis of the current legislative and policy framework. This involves an examination of the work and significance of the MacLean and Millan Committees, set against the background of a policy framework by the UK Government explicitly predicated on preventive detention and the belief that dangerousness can in effect be diagnosed.

Chapter 5 provides details of the methodology and theoretical considerations that have provided the framework for the process of enquiry and analysis upon which this thesis is based. This chapter is intended to provide the reader with a clear insight into the value commitments and theoretical perspectives that have informed and structured the design, implementation, analysis, presentation of findings and conclusions that constitute this thesis. The findings emerging from the empirical enquiry and informed by the preceding literature review are presented in three chapters together with key findings.

Chapter 6 focuses on the emergent themes that centre upon attitudes, expectations, service boundaries and the roles played by different professionals. The views and perceptions of a range of professionals and key informants are explored in order to provide a framework in which to understand current practice and its potential impact upon those who

attract a diagnosis of personality disorder. Continuing ambivalence both towards the diagnosis of personality disorder itself and those to whom this diagnosis is given, together with expectations of service users that are inherently problematic as well as boundaries between services emerged as particularly significant.

Chapter 7 focuses upon how services are structured and resources deployed in response to the needs of service users. Specific consideration is given to the accessibility of services and the growing tension between the public and private provision of services. The potential significance of the personality disorder network is discussed.

Chapter 8 contextualises policy and practice within a broader neoliberal policy framework and explores the different emphasis that is given to personality disorder in its various forms of diagnosis within policy frameworks and strategies. The significance of key policy devices such as Health Efficiency and Access Times (HEAT targets) are examined within this chapter. The omission of personality disorder from the HEAT target for waiting times for psychological therapy is identified as having particular relevance to the way that resources are allocated and services structured.

Chapter 9 contains a number of specific conclusions based upon the key findings together with the identification of areas that require further enquiry.

Chapter 2:

The shifting sands of diagnosis – Personality disorder and the construction of spoiled identities

In order to understand how and why a diagnosis of personality disorder came to be regarded as so fundamentally problematic by service users and clinicians alike, it is necessary to begin by considering the conceptual origins and history of the development of this diagnosis within the broader context of psychiatric nosology. This chapter will therefore explore the origins, development and classification of the diagnosis of personality disorder.

The diagnosis of personality disorder has been and remains contentious in part as a consequence of the on-going debate regarding its legitimacy and diagnostic reliability (Clark, Livesley et al. 1997; Tyrer, Coombs et al. 2007). The diagnosis of personality disorder has also proved contentious due to its historical status as a diagnosis of exclusion. The status of personality disorder as a diagnosis of exclusion will be discussed in order to contextualise the subsequent review and analysis of the processes of policy and legislative reform.

The Damning Effects of a Spoiled Identity

As Goffman observed, apparent deviations from what are perceived to be normal personality traits are frequently regarded as blemishes of character (Goffman 1963). This insight is significant because it may offer a partial explanation for the tendency among many professionals to adopt a punitive or dismissive attitude towards those who attract a diagnosis of personality disorder (Lewis and Appleby 1988; Tredget 2001). Goffman's use of the concept of stigma resonates with Foucault's analysis of those who come to be regarded as monstrous due to their perceived abnormalities (Foucault 2003). Goffman contended that:

> "By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on the differences, such as those of social class":15.

The stigma associated with perceived abnormality is evident throughout the history of personality disorder from the early descriptions of progenitor diagnoses such as moral insanity to the modern construction of the concept of the psychopath; this will be explored further under the heading: Moral Insanity and the Construction of Personality Disorder.

Receiving a diagnosis of a personality disorder has profound implications, not least because it is "a very sticky label" (Haigh 2002:1) that carries both a high degree of stigma and promotes a sense of hopelessness due to historical pessimism regarding its treatability (Nehls 1998; Stalker, Ferguson et al. 2005). The problem is further compounded by the fact that two very different approaches to the treatment and care of those who attract a diagnosis of personality disorder can be identified, such that those who are deemed to be 'risky', particularly in terms of risk to others are likely to be subject to more stringent measures of control, while those who are deemed less 'risky' may continue to be regarded as a nuisance (Kendell 2002) and therefore experience difficulties accessing support. One vision of the future suggests that:

> "...mental health policies in the 21st century will revolve around compulsory treatment and surveillance in the community for those deemed high-risk and isolation and invisibility, amounting to segregation, for those deemed low risk" (Stalker 2003:221).

Whether or not this prediction is likely to become a reality in Scotland is an empirical question requiring further investigation, and as such, it forms a key element within the research at the core of this thesis. The outcome is of considerable importance given the potential impact of being diagnosed with a personality disorder and thereby acquiring a spoiled identity. Given that such a diagnosis renders individuals liable to fall within one of two categories: namely that of a potentially inconvenient problem or a risk to be managed, it is unsurprising that such a diagnosis

causes its own distress: this may in turn compound any other challenges experienced in the course of daily life by those who receive such a diagnosis (Ferguson, Barclay et al. 2003).

Personality Disorder Today-Conceptual Frameworks and Contentious Issues

During the time that this research was planned and conducted there were two major diagnostic frameworks that provide clinical definitions of personality disorder: namely the International Classification of Diseases published by the World Health Organisation (ICD-10) and the Diagnostic and Statistical Manual published by the American Psychiatric Association (DSM-IV-TR). While acknowledging some overlap between categories, both the ICD-10 and DSM-IV-TR utilise categorical diagnostic classification systems on the premise that distinct personality disorders with discrete clinical syndromes can be identified (Tredget 2001). An alternative approach increasingly favoured by many is that of the dimensional model that views personality disorders as:

> "maladaptive variants of personality traits that merge imperceptibly into normality and into one another" (American Psychiatric Association 2000:689).

This alternative model for understanding personality disorder is not a recent development, having been advocated for example by Koch in

respect of psychopathic inferiorities (Pichot 1978). The weight of empirical evidence suggests that personality may more accurately be understood in terms of a continuum, ranging from statistical normality to abnormality based upon a dimensional model (Moran 2002; Clark 2006) rather than a categorical one. This approach proved to be significant in the debate concerning proposed revisions to both systems of diagnostic classification. This debate has not abated following the publication of a further iteration of the DSM in the form of DSM-V. Advocates of the categorical approach maintain however, that it has particular utility for practitioners when trying to make decisions regarding treatment. It has been argued that the preference either for a categorical / typological or dimensional approach amount to little more than "quasi-ideological preferences" (Lenzenweger and Clarkin 2005):12.

The categorical / typological approach has been traditionally preferred among psychiatrists, reflecting the origins of psychiatry within medicine. This approach is consistent with the traditional role of the medical clinician of making specific diagnoses and prescribing specific treatments. It should be noted that despite widely reported discussions within the DSM 5 Working Group concerning radical revisions to the category of personality disorder, that DSM 5 published in May 2013 contains relatively limited changes. The main changes are the adoption of a hybrid dimensional-categorical model and some changes to categories of specific subgroups of personality disorders (Stetka and Correll, 2013). The extent to which these will be reflected in further iterations of the ICD remains to be seen. ICD 11 is currently scheduled for release in 2015.

Despite certain differences in nomenclature e.g. the use of the term dissocial personality disorder within The International Classification of Diseases (ICD-10) and antisocial personality disorder within The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) and differences in the way that borderline personality disorder is included, the two taxonomies share a common view regarding personality disorder (Moran and Hagell 2001). The commonality between these two systems reflects a deliberate attempt to achieve harmonisation between the two classification systems (American Psychiatric Association 2000). Personality disorder is defined within ICD-10 as:

> "...deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given 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 of social performance" (World Health Organisation 2007).

Both the ICD and DSM taxonomies rely upon trait theory for their basic explanatory framework for personality disorder. Personality traits and their relationship to personality have been defined as:

> "...enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders" (American Psychiatric Association 2000:686).

The construction of personality disorder within both taxonomies is based upon four criteria (Mombour and Bronisch 1998) namely: 1) that the characteristic and enduring patterns of inner experience and behaviour of an individual deviate substantially from normal cultural expectations i.e. social norms 2) that any deviation must be maladaptive, inflexible or in some other sense dysfunctional within the individual's social environment across a range of situations 3) that these deviations must result in personal distress or a negative impact upon others within the individual's social environment 4) it is necessary that the deviation is not transient but rather that it is enduring (Tyrer 2007).

Various estimates of the prevalence of personality disorder have been calculated suggesting that approximately 10% of those within community samples exhibit problems that meet the diagnostic criteria for one or more personality disorders. The estimates of prevalence within specific subpopulations however, perhaps unsurprisingly, yield far higher percentages i.e. approximately 30% within primary care, 30% to 40% of psychiatric outpatients and 40% to 50% of psychiatric inpatients. Some estimates place the rate amongst psychiatric outpatients as in excess of

80%, 50% to 78% of adult prisoners, 70% of male mentally disordered offenders with an even higher percentage for women within forensic psychiatric settings (Alwin, Blackburn et al. 2006).

So-called 'normal' personality research, largely conducted within the field of psychology, has in contrast traditionally been based upon an assumption of a continuum, thereby leading to a preference for dimensional models. This reflects the methodology that has underpinned the development of clinical psychology, being based upon the extensive use of statistical models intended to identify patterns of distribution and correlations within and between various hypothesised personality traits. This approach has characterised research within the field of psychology from its emergence as a distinct field of study, with personality as its central organising focus.

The different approaches adopted within psychiatry and psychology to understanding personality and the diagnosis of personality disorder more specifically, have led to substantial areas of disagreement that are evident in debates concerning the legitimacy and utility of the current systems of diagnostic classification. This area of disagreement is well illustrated by the views expressed by one psychologist at the State Hospital, who in response to the consultation exercise undertaken by the McLean Committee, offered the view that the methods used by psychologists were inherently superior to those typically used within psychiatry because:

> "They do not require a complex and highly dubious diagnostic system…" (McGinley 1999, para 4).

This criticism has been followed more recently by a full-blown assault launched by a branch of the British Psychological Society against the dominant systems of psychiatric classification including ICD 10 and DSM 5 (Division of Clinical Psychology 2013). Such debates as this are significant precisely because the outcome of the process of diagnosis has direct and substantial implications for service users, not least because it is likely to influence the treatment options, if any, that are made available to them. A diagnosis of personality disorder is predicated upon an assessment of who a person is based upon their characteristic traits, rather than how they are coping with particular circumstances at a particular time. The fact that human behaviour is susceptible to the influence of context however creates considerable room for error and misclassification: this is typically referred to as the trait-state tension (Casey 1997).

Concerns regarding inconsistencies in the diagnosis of personality disorders have led to an increasing emphasis upon maximising inter-rater reliability when revisions to the systems of classification have been introduced. This has been achieved by increasing the focus upon description rather than explanation (Kirk and Kutchins 1992). Despite these efforts however, considerable inconsistencies can be identified within the overall process of diagnosis, specifically with reference to comorbidity (Pincus, Tew et al. 2004). Once again this has substantial implications for those who receive a diagnosis of personality disorder, as

it implies that the precise combination of diagnoses that an individual is likely to receive is fairly arbitrary. The diagnosis of borderline personality disorder in particular has been identified as subject to a particularly high error rate (Pincus, Tew et al. 2004). This has significant implications for the welfare and rights of those who are given such a diagnosis, as the recorded diagnosis will inevitably influence what care and treatment plan the service user is deemed likely to benefit from. This lack of conceptual clarity has also been said to have contributed to the demonisation of many of those diagnosed with psychopathic personality disorder (Blackburn 2000).

Alternative Aetiological Explanations - Some Implications

A range of competing explanations (Alwin, Blackburn et al. 2006) can be identified for the origins of personality disorder. The psychodynamic perspective based on object relations, emphasises the importance of early attachments (Page 2001). Behavioural models focus upon the functions of behaviour; therefore their proponents tend to regard concepts such as personality disorder and personality traits as unhelpful on the grounds that they operate only at the level of description. Cognitive approaches focus upon information processing, particularly the role of memory and the significance of social learning processes. Personology (Millon and Grossman 2005) provides an alternative explanatory framework that views behaviours as existing on a continuum of adaptive to maladaptive, based on the evolutionary principles of adaptation and natural selection.

This approach finds common ground with certain cognitive models in the belief that human physiological evolution has not kept pace with social change, leading to the retention of information biases that are maladaptive in modern human societies (Pretzer and Beck 2005:43).

These latter approaches have much in common with socio-biological attempts to integrate genetics and evolutionary theory in order to provide a model for understanding psychopathology. One implication of this latter approach is that psychopathology should more accurately be viewed as adaptive and not pathological at all. While the pathological view regards the thought processes and patterns of behaviour associated with the diagnosis of psychopathy for example, as clearly psychopathological, this alternative view regards psychopathy as an example of "special design" (Crawford and Salmon 2002:43) and a legacy of the evolutionary history of our species. From this perspective psychopathy is a behavioural strategy based on manipulation, aggression and risk taking intended to facilitate social dominance and maximise reproductive success. This proposition is consistent with the observation that by no means all psychopaths are criminals but that many are successful in professional and business life (Hare 1993). This alternative approach to understanding pathology reframes the notion of pathology itself as a particular form of social disapproval. What sets this particular form of social disapproval apart is that it is accorded legitimacy by being incorporated within and expressed through medical terminology.

A further approach is based upon conceptualising personality disorder as a psychological and behavioural response to trauma, often associated with but not limited to early attachment experiences (Johnson 2010). This emphasis upon trauma is also strongly reflected within the recent statement released by the British Psychological Society referred to previously (Division of Clinical Psychology 2013). Some evidence from service users themselves suggests a strong correlation between trauma, notably abuse, particularly in childhood and a subsequent diagnosis of a personality disorder (Stalker, Ferguson et al. 2005).

The approaches favoured by clinicians and policy makers towards those who attract this label have very significant implications for service users in terms of how their needs are understood and provided for. In light of this specific consideration will be given later within this thesis to the implications of the increasing prominence being given to a trauma-based perspective to understanding personality disorders.

Diagnostic Reliability

Personality disorder has been described as:

> "...a dustbin category of problematic 'behaviour' as judged by significant others or staff"" (Pilgrim 2001,:255).

This echoes an earlier observation that certain diagnoses of personality disorder had become:

> "...a psychiatric waste basket for a heterogeneous collection of illnesses with etiologies which were not known and with clinical pictures which differed in essential elements" (Robins 1967,:951).

Efforts to disaggregate the concept of personality disorder from mental illness during the 20th century have been attributed to the continued moral and value-laden basis of the construct, and the processes of assessing and reaching a diagnosis of personality disorder (Pilgrim 2001). The move towards more descriptive approaches found most notably within DSM-IV and to a lesser extent within ICD-10, is attributable to increasing recognition of the lack of any substantive understanding of the aetiology of personality disorder (Kirk and Kutchins 1992). This trend towards a more descriptive approach has led to an increase in the rate of comorbid diagnosis within both diagnostic systems; this can be attributed to the development process of the ICD-10 diagnostic research criteria*:* namely that they were designed to align with DSM-III-R in order to promote and assist in the coordination of research (WHO 1992; Cooper 2004). One of the costs of efforts to achieve greater alignment was that of a shift towards a greater emphasis on description at the expense of more clearly delineated concepts. In becoming more descriptive both the ICD and DSM systems have become increasingly "atheoretical" during their various revisions and have thereby promoted multiple diagnoses (Pincus, Tew et al. 2004):18. This has been described as a:

> "strategy of diagnosing 'maximal' comorbidity" at the potential expense of "'optimal' comorbidity" (Pincus, Tew et al. 2004):18.

This in effect means that the number and range of diagnoses that are being made is perhaps more strongly related to the changes to the systems of classification than to the nature of the phenomena themselves.

In addition to the debate as to whether a diagnosis of personality disorder should be understood in categorical or dimensional terms, another fundamental tension concerns one of the basic premises of the diagnosis of a personality disorder: namely that it is characterised by enduring patterns of behaviour. Emerging research casts doubt on the extent to which the patterns of behaviour underpinning the diagnosis of personality disorder are in fact generally stable at all, most notably among those who seek treatment (Tyrer, Coombs et al. 2007). The significance of this last point can hardly be overstated given that the stability of traits and enduring patterns of behaviour are fundamental to how personality disorder is conceptualised within the existing systems of classification. These shifting sands of diagnostic boundaries are likely to be of on-going significance, not least as a result of the revisions to the DSM including the lowering of diagnostic thresholds that may also in due course influence the ICD thereby drawing a much larger pool of people into those who attract specific psychiatric labels including that of personality disorder (Skodol, Bender et al. 2011; Insel, 2013).

Evidence of the high level of comorbid diagnosis of personality disorder with mental illness (Moran 2002; Clark 2006) also raises questions regarding the extent to which personality disorder should be categorised separately from mental illness (Pilgrim 2001). The implication is that personality disorder serves a particular function; namely that of separating out those individuals who are considered too problematic for professionals to engage with and for whom the prospect of successful treatment is deemed to be particularly poor. Historically, given the strong association between personality disorder and the commonly held perception that those who attract this diagnosis are likely to be unresponsive to treatment, reinforced by stereotypical assumptions concerning the challenging behaviour displayed by some of those who may attract this diagnosis (Tyrer, Casey et al. 1991), it is perhaps unsurprising that personality disorder came to be regarded as a diagnosis of exclusion (Ogloff 2006). The perceived 'failure' of those with personality disorder to comply with the rigours of the sick role (Rush 2004) and the tendency among some of those with personality disorder to act in ways that are "disconfirming of the professional role" (Bowers, Carr-Walker et al. 2006:1), may also in part explain the frequently punitive and dismissive attitude faced by those who attract this diagnosis from professionals: this will be discussed further within the findings of this thesis by using the concept of service readiness. These negative and punitive attitudes appear to be in part based upon the belief that those who have been given a diagnosis of personality disorder are responsible for:

> "...sucking in services in response to a crisis or as 'abusers' of services rather than 'users'" (Tredget 2001:349).

This punitive or sometimes ambivalent attitude towards those who attract a diagnosis of personality disorder can perhaps also be attributed to continuing uncertainty regarding treatment efficacy, notwithstanding emerging research findings that give some cause for therapeutic optimism. Scepticism concerning treatment efficacy is compounded by a lack of consensus concerning the aetiology of this diagnosis. This scepticism is particularly evident but not limited to the diagnoses of psychopathic and antisocial personality disorders (Dolan and Coid 1993; Warren, McGauley et al. 2003). The current lack of consensus concerning personality disorder has led some to conclude that this diagnosis is:

> "...shrouded in speculation and there is very little research based evidence on the subject" (Tredget 2001:354).

Evidence of the reluctance among some professionals to engage with those who attract a diagnosis of personality disorder, can be found within the responses to the consultation exercise undertaken by the MacLean Committee; this will be explored further within chapter 4 of this thesis. A specific example of this reticence can be found in a narrowly defeated motion at a meeting of the Royal College of Psychiatrists at the turn of the millennium, urging that:

> "...general psychiatrists should abandon treating personality-disordered patients" (Mann and Moran 2000,:11).

Evidence of therapeutic pessimism, hostility towards and a general reluctance to engage with those have received a diagnosis of personality disorder has also been identified as a significant problem within specialist settings (Tyrer and Simonsen 2003; Bowers, Carr-Walker et al. 2006). These tensions may also offer some explanation for the fact that, despite the general acceptance among professionals (Ferguson, Barclay et al. 2003) of the broad categories of personality disorder, fundamental issues remain unresolved and form the basis for on-going debate. This debate in part concerns how individual categories of personality disorder should be defined and the degree of rigidity that ought to exist between them (Clark, Liversley et al. 1997). The lack of agreement regarding these fundamental issues, together with a lack of agreement regarding the aetiology of personality disorder has led to criticisms that:

> "Current models and theories of personality and personality disorders are mostly based on academic speculations. They bear very little, if any, empirical support" (Tyrer and Simonsen 2003,:42).

Consequently it has been argued that the diagnosis of personality disorder is "fundamentally flawed" (Pilgrim 2001,:253). Evidence of a gender-based distortion in the assessment of personality disorder has also led to suggestions that personality disorders themselves may to some extent:

> "...represent no more than exaggerated sex-role stereotypes" (Moran 2002,:9).

Evidence for this can be found in the relative rates of the diagnosis of borderline personality disorder for men and women, such that borderline personality disorder has largely become regarded as a disorder of the pathological female personality (Nehls 1998). Research also indicates that men are more likely than women to be diagnosed with antisocial personality disorder (Alwin, Blackburn et al. 2006). This critique of the apparent relationship between diagnosis and sex-role stereotypes has been extended to assert that personality disorder does not exist outside of professional discourses (Pilgrim 2002).

The adoption of the term 'disorder' within DSM-I and its subsequent use within revisions to the DSM and also ICD has been viewed by some critics as an attempt to sidestep the debate concerning some of these fundamental issues (Jablensky 2004). The term disorder itself however:

> "...has no clear correspondence with either the concept of disease or the concept of syndrome in medical classifications" (Jablensky 2004,:25).

The use of this term has the effect of encouraging the perception that the 'disorders' contained within ICD-10 and DSM-IV are "quasi-disease entities" (Jablensky 2004,:25) ; this results in a significantly increased frequency of diagnosed comorbidity due to:

> "...the fragmentation of psychopathology into a large number of 'disorders', of which many are merely syndromes. This blurs the distinction between true and spurious comorbidity":25.

This may help to explain why:

> "...psychiatric disorders, one way or another, similarly or differently, hydra-headed keep appearing" (Ball 1998,:743).

This conceptual confusion therefore implies that the:

> "...fundamental assumptions of the dominant diagnostic schemata may be incorrect" (Jablensky 2004,:25).

Those who may attract a diagnosis of personality disorder represent a heterogeneous population. The process of classification and diagnosis is dependent upon a range of embedded normative value judgments. This inevitably follows from the basic assumptions that underpin the existence of the construct of personality disorder; namely that at a certain point "quantitative deviations" (Munro and McCulloch 1969:124) from a normative standard are constructed as a disorder of the personality. The construct of personality disorder has therefore been called into question by the inevitable degree of cultural and social relativism inherent within the diagnosis (Pilgrim 2001).

Some critics, most notably Pilgrim (2001), have sought to illustrate this latter point by making reference to extreme cases, for example how opposition to the Nazi regime in Germany and apartheid in South Africa should be viewed. How should the concept of personality disorder be applied in examples when social norms based upon universal human rights are completely inverted as in the above cases? It is a definitional necessity that personality disorder, if regarded as having any legitimacy at all, must be defined against a perceived standard of normality; this in turn means however that the diagnosis is in reality a measure of the perceived social 'distance' between a given individual and the population in which they are situated. The debate regarding the extent to which psychopathology should be regarded as emic, that is culturally specific or etic, that is universal also remains contentious. Proponents of an etic interpretation, citing research based on standardised assessment instruments, have however countered that apparent cultural differences can be understood in terms of differences in the presentation of problems but that they are not indicative of any difference in the underlying disorders (Cheng 2001).

The process of diagnosis used within psychiatry, particularly relating to categorical systems of classification can be understood as representing an extreme example of a power imbalance between clinicians and service users:

> "I'll tell you who you are so hop in that box and shut up" (Blomfield 1998,:745).

More benign interpretations however emphasise the pragmatic benefits of such an approach:

> "...the categorical approach neatly maps onto the decision of whether to provide treatment or not to provide treatment... With a single categorical diagnosis it does simplify the choice of clinical focus and appropriate treatment for that PD" (Thompson and MacDonald 2011) .

Treatment Efficacy and the Pessimism-Optimism Continuum

The available range of interventions used by clinicians in working with those who attract a diagnosis of personality disorder in part reflects the different views of how psychopathology and personality disorders more specifically can be best understood. Partly as a consequence of these differences, the available research evidence concerning treatment efficacy gives rise to varying degrees of therapeutic optimism and pessimism. Advocates of therapeutic optimism generally point to cognitive behavioural interventions (Sperry 2006), or the more recent development of approaches such as dialectical behaviour therapy: (Bohus, Haaf et al. 2000; Tredget 2001; Palmer 2002) the latter being a hybrid based on cognitive behavioural theory, social learning theory and insights drawn from Zen Buddhism. One study conducted in the United Kingdom concerning the addition of cognitive behavioural treatment to treatment as usual, for those given a diagnosis of borderline personality disorder,

found significant reductions in suicidal and self-harming behaviours (Davidson, Norrie et al. 2006). As well as the focus upon psychological interventions, drug treatment has also been advocated on the basis that it can provide an effective means of managing distressing symptoms at least as effectively as psychological interventions (Tyrer and Bateman 2004) and at a potentially lower cost. Growing recognition of the potential benefits of treatment, have resulted in the publication of specific guidelines for England and Wales concerning antisocial (National Institute of Clinical Excellence 2009) (NICE) (guideline 77) and borderline personality disorder (guideline 78). These guidelines do however explicitly acknowledge significant limitations within the available evidence.

Increased optimism regarding the potential for more positive outcomes, has in part provided the rationale for increasing demands to end the exclusionary status of personality disorder. The inclusion of personality disorders within both the DSM-III and ICD-9, starting in the 1980s, provided a platform against which to both conduct further research and challenge the acceptance of an overly pessimistic therapeutic outlook (Ferguson, Barclay et al. 2003; Lenzenweger and Clarkin 2005). A major policy initiative was launched in 2003 by the Department of Health for England/Wales (National Institute for Mental Health in England 2003), with the express intention of challenging the status of personality disorder as a diagnosis of exclusion. This policy has no specific counterpart in Scotland; however it should be noted that personality disorder was retained in mental health legislation enacted that same year i.e. the (Mental Health (Care and Treatment) (Scotland) Act 2003). It should also

be noted that borderline personality disorder has been included within the matrix of psychological therapies (NHS Education Board for Scotland 2008) intended to operate in a broadly similar, although less prescriptive manner to the NICE guidelines for England and Wales: this specific development within Scotland will be discussed more fully in chapter 8 of this thesis. The absence of a single clear policy of explicit inclusion within Scotland should however be noted, the implications of this will be discussed later in this thesis.

Evidence of continuing scepticism regarding the potential efficacy of available treatment models can however be readily identified; these are most evident in relation to those who attract a diagnosis of psychopathic personality disorder. The MacLean Committee for example sounded a distinctively cautious note in asserting that:

> "Over the years, there have been many false dawns" (MacLean 2000) para 11.22.

In summary for those who attract a diagnosis of personality disorder, the evidence concerning the effectiveness of available interventions in alleviating symptoms that are distressing for the individual and or others remains ambiguous. The picture that appears to be emerging is that some treatments are probably effective for some people some of the time.

Moral Insanity and the Construction of Personality Disorder

Moral insanity is often referred to as the original description of the psychopathic personality (Berrios 1999); consequently the development of moral insanity and its relationship to personality disorder will now be given further consideration.

Philippe Pinel (1745-1826) is generally credited with providing the first clinical descriptions of what was to become known as moral insanity and eventually psychopathy (Fallon, Bluglass et al. 1999; Pilgrim 2001). Pinel argued that he had identified a distinctive sub-group of patients who did not conform to any existing category. Pinel coined the term 'manie sans délire' meaning madness but without delirium (Arrigo and Shipley 2001). In his 'Medico-psychological treatise on mental alienation' published in 1809 (Pichot 1978), Pinel provided three case histories concerning patients apparently free from any disturbance or defect of their senses and understanding, but who were nevertheless dominated by an instinctive tendency towards fury (instinct de fureur). The fundamental diagnostic criterion identified by Pinel that was to be of recurring significance, was that of affective but not cognitive impairment i.e. emotional but not cognitive dysregulation.

Pinel attributed the development of this disorder to both exogenous and endogenous factors - a twin focus that was to remain central to on-going debate concerning the aetiology and diagnosis of personality disorder. Pinel's work is noteworthy (Rafter 2004) not least because he was among

the first leading European thinkers to argue that mental disorder, whatever its origins, should be regarded as a disease. This is an example of the enlightenment legacy characterised in part by a move away from theological explanations for human behaviour, to those based on the emerging sciences in the pursuit of explicitly rational explanations for observed phenomena. The tension between theological and scientific approaches, was however to remain a significant feature of debates regarding both the aetiology and treatment of mental disorder for some time.

Benjamin Rush (1745–1813) who is widely regarded as the founder of psychiatry within the USA, shared Pinel's view that moral derangement and insanity should be understood as disease processes rather than attributable to the punishment of God or demonic possession (Rafter 2004). As the seminal thinker within North American psychiatry, Rush's ideas were to be of lasting significance, notably his adoption of faculty psychology for the explanation for what would come to be known as moral insanity (Ellard 1988). Faculties according to Rush were analogous to internal senses. These senses rather like their external counterparts could become impaired or indeed be impaired at birth. Rush identified nine different faculties including the conscience, moral faculty and sense of God, thereby reintroducing a theological dimension. In cases of partial moral derangement, this was explained in terms of a failure only of the moral faculty but the continued functioning of "a sound conscience and sense of God" (Rafter 2004,:987). In cases of total moral derangement however, both the conscience and sense of God, together with the moral

faculty were said to be malfunctioning "...producing people who commit crimes repeatedly and without remorse" (Rafter 2004,:988).

Whereas Pinel and Rush appear to have developed their ideas relatively independently (Rafter 2004), the work of Esquirol and Prichard was to some extent based upon an exchange of ideas (Pichot 1978). Esquirol, a student of Pinel who succeeded him as the chief physician of the Salpêtriere Hospital in 1811, originated the concept of *monomanias*, published in detail within his treatise of 1838. Esquirol argued that even amongst those who were insane, that any defect of understanding was not the primary cause of behaviour that in the case of the sane would be regarded as criminal (Pichot 1978). Esquirol's logic is an example of the tension that was later to become characteristic of legal debates concerning the diagnosis of personality disorder, namely the focus upon questions of culpability and diminished responsibility. This debate in turn reflects a fundamental ambivalence about whether or not those with a diagnosis of personality disorder should simply be punished for their actions or regarded as in need of treatment; this will be discussed in detail within the next chapter of this thesis.

Prichard, working in England, developed his concept of moral insanity by also drawing upon faculty psychology. Prichard's concept of moral insanity was published more fully in his treatise of 1835, after he had first introduced the concept in his contribution to the Cyclopaedia of Practical Medicine in 1832. Prichard defined the concept as follows:

> "Moral Insanity, or madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits and moral dispositions, without any notable lesion of the intellect or knowing or reasoning faculties, and particularly without any maniacal hallucinations" (Dopson 1949,:228).

The 1837 edition of Prichard's treatise, dedicated to Esquirol and entitled: 'A Treatise on Insanity and Other Disorders Affecting the Mind', contains the same definition of moral insanity as appeared within the Cyclopaedia, but with the addition of the words "and natural impulses" after moral dispositions (Prichard 1837). Prichard's treatise ensured that moral insanity became inscribed into medical nosology (Augstein 1996). Prichard acknowledged that his own work had been significantly influenced by Pinel, also asserting that Esquirol equally acknowledged his debt to Pinel (Prichard 1837). Whilst acknowledging his debt to Pinel however, Prichard adopted a more punitive position towards those who become classified within this diagnostic grouping. Prichard emphasised that those who were afflicted by moral insanity retained the knowledge of right and wrong and should therefore be regarded as culpable for their behaviour (Arrigo and Shipley 2001).

Moral insanity is often taken to represent the historical origin of the concept of the psychopath (Blair, Jopnes et al. 1995). The clinical observations that provided the basis for the articulation of the concept of moral insanity were however based on fairly heterogeneous cases, only some of which would clearly correspond to the later construct of

psychopathy (Pichot 1978). The heterogeneity of the cases reported by Prichard and the frequency with which his patients recovered, has caused some to question whether the common practice of attributing moral insanity with being the first description of psychopathic personality disorder is in fact appropriate (Whitlock 1982; Berrios 1999).
Prichard described a form of congenital moral deficiency analogous to a congenital deficiency of intelligence. Prichard suggested that moral insanity occurred within the community at a relatively high frequency stating:

> "There are many individuals living at large, and not entirely separated from society, who are affected in a certain degree with this modification of insanity" (Prichard 1837,:20).

Prichard's terminology found a place within the parallel mental health legislation passed in the Mental Deficiency Act 1913 and the Mental Deficiency and Lunacy (Scotland) Act 1913. The significance of this legislation will be discussed in further detail in the next chapter.
Prichard's terminology also gained favour in the USA and was adopted in preference to previous formulations including that of Rush. Prichard's terminology was ultimately to become "a lightning rod for tensions that divided American psychiatry" (Rafter 2004,:995), based in part upon personal disagreements between Isaac Ray and John Gray. Ray was an advocate of moral insanity (Stearns 1945) in the terms set out by Rush and Pritchard based on distinct faculties. Gray however was among those

who argued that emotional madness could not exist in the absence of some causal cognitive impairment.

Despite his expressed opposition to such an interpretation, increasing opposition to Prichard's typology also emerged from those concerned that moral insanity provided a socially unacceptable defence for criminals. This latter issue will be discussed further in the next chapter as it has continued to provide a tension within legal frameworks in many jurisdictions. The status of the construct moral insanity was however ultimately undermined not by these concerns, but rather by the ascendancy of theories of mental degeneracy, these will be discussed shortly (Rafter 2004).

It has also been suggested that Prichard's use of the term moral, should not be taken as a reference to morality as such but rather to the emotions (Ellard 1989) or psychological factors (Fallon, Bluglass et al. 1999). Proponents of this view argue that Prichard's use of the term moral followed Esquirol's use of the term (Prichard 1837) 'moral alienation' and referred to an emotional disconnectedness with others: this interpretation sits within the branch of psychology concerned with affect, namely the way in which emotions influence the process of decision-making and relating to others (Norman 2004; Bjørnebekk 2008). A counter argument has however been advanced based on the premise that Prichard's concept of moral insanity should be understood as having a dual focus upon morality in terms of sin (Augstein 1996), as well as a lack of emotional attachment. This dual focus can be attributed to Prichard's acceptance of

moral depravity and sin as the fundamental causes of madness (Augstein 1996). These tensions within Prichard's construct of moral insanity can be understood by considering the context of its development. The concept of moral insanity proposed by Prichard was developed to serve a specific function in response to particular concerns, these centred upon the perceived increasingly morally irresponsible conduct within certain sections of society. The function served by this concept was therefore that of providing:

> "...a model disease which explained in psychiatric terms the despicable moral corruption of his times and, in particular, of the affluent, who had the means to indulge in "moral debasement" until they went mad" (Augstein 1996,:340).

This observation is of fundamental importance because it highlights the origin of the construct of personality disorder in terms of its functional purpose, namely that of inscribing within medical discourse concepts capable of describing behaviours perceived as leading to or being caused by patterns of behaviour - specifically behaviours associated with the erosion of normative moral standards. This same process can be observed in the emergence and prominence given to diagnoses such as 'attention deficit hyperactivity disorder' (Comstock 2011). The conflation of medicine and morality in respect of those classified as having a personality disorder, was subsequently compounded by Isaac Ray with his concept of moral mania (McCallum 2001) and by Edward Spitzka's description of moral imbecility (McCallum 2001; Rafter 2004).

The term moral insanity was subsequently superseded by that of psychopathic inferiority; this term provided a broad category that came to represent "all personality disorders" (Arrigo and Shipley 2001:331). Psychopathic inferiority in keeping with moral insanity also emphasised abnormality without insanity (Ellard 1989). Koch's formulation (Koch 1891) however did not place particular emphasis upon moral depravity or wickedness (Pichot 1978).

The emphasis upon morality was however very much to the fore within the doctrine of mental degeneracy developed by Morel (Morel 1857; Dowbiggin 1996; Warren and South 2006). Degeneracy was viewed from a theological perspective drawing upon the idea of 'the fall'. Mental degeneracy was attributed to the adverse effects of sin upon successive generations of humanity. Morel (Pichot 1978) also embraced Pinel's concept of 'manie sans délire' in keeping with Esquirol and Prichard. Degeneracy theory was subsequently revised by Magnum (Dowbiggin 1996), who substituted Darwin's ideas of heredity in place of theology.

The concept of heritability continued to be given prominence in explanations of the development of psychopathology and influenced Koch's notion of psychopathic inferiority introduced in his treatise of 1891 (Arrigo and Shipley 2001). Koch's efforts to promote a congenital explanation for the development of psychopathology were ultimately stifled by the growing emphasis on the significance of exogenous factors that would lead to the emergence of the construct of sociopathy (Arrigo and Shipley 2001). This de-emphasising of congenital factors is also said

to have undermined Koch's efforts to reduce the social condemnation associated with what subsequently become defined as personality disorder (Arrigo and Shipley 2001). The British psychiatrist Henry Maudsley among others attempted to maintain a focus upon congenital aetiological explanations, arguing that those classified as moral imbeciles were incapable of being rehabilitated and that consequently, "it was useless to punish those who could not control their actions" (Arrigo and Shipley 2001,:332). These tensions concerning the emphasis that should be given to moral failings or congenital factors are significant because they influence the form of stigma that those who may attract a diagnosis of personality disorder are likely to experience.

This pessimistic view of the treatment prospects for this particular group was reinforced by Krafft-Ebing (Arrigo and Shipley 2001), who identified a group of offences and offenders under the heading of 'lustmurder' (Krafft-Ebing 1886/1997). Krafft-Ebing emphasised the wilful and predatory nature of the offences described under this heading detailing examples of the most gruesome sexual and violent assaults, together with cruelty to animals and acts of cannibalism. The clinical descriptions provided under this heading share many of the similarities with the subsequent descriptions of the psychopath, a term coined by Cleckley (Grann, Langstrom et al. 1999) in The Mask of Sanity (Cleckley 1941).

Koch's concept of psychopathic inferiority was utilised by Kraepelin, who adopted the term psychopathic states in the fifth edition of his treatise published in 1896 (Pichot 1978). Kraepelin added to Koch's typology of

psychopathic inferiority by identifying additional categories based on "the most vicious and wicked of disordered offenders" (Arrigo and Shipley 2001,:333). For Kraepelin psychopathy was "no longer a quantitative description, but a firm category. Its heredity was beyond doubt" (Ellard 1989,:127). This increased emphasis upon wickedness led to psychopathy becoming synonymous with moral defectiveness (Ellard 1989). Kraepelin's formulations also bore a close resemblance to modern constructions of psychopathy as subsequently developed by Cleckley (1941) and to antisocial personality disorder as currently formulated within the textual notes of DSM-IV-TR and in ICD-10 as dissocial personality disorder. Kraepelin described this group as:

> "...the enemies of society… characterised by a blunting of the moral elements. They are often destructive and threatening… there is a lack of deep emotional reaction; and of sympathy and affection they have little. They are apt to have been troublesome in school, given to truancy and running away. Early thievery is common among them and they commit crimes of various kinds" quoted in (Arrigo and Shipley 2001,:334).

Differences in the emphasis that should be placed upon morality in understanding psychopathy eventually led to substantially different constructions of the psychopath within Europe and North America such that:

> "American psychopaths were wicked, while European psychopaths were merely statistically and amorally deviant" (Ellard 1989:129).

Cleckley (1941) provided the basis for "the modern clinical construct of psychopathy" (Arrigo and Shipley 2001,:334). The 1976 (5th) edition contains the following characteristics of the psychopath: "1. Superficial charm and good "intelligence"; 2. Absence of delusions and other signs of irrational thinking; 3. Absence of "nervousness" or psychoneurotic manifestations; 4. Unreliability; 5. Untruthfulness and insincerity; 6. Lack of remorse or shame; 7. Inadequately motivated antisocial behaviour; 8. Poor judgment and failure to learn by experience; 9. Pathologic egocentricity and incapacity for love; 10. General poverty in major affective reactions; 11. Specific loss of insight".

Cleckley (1976) acknowledged the lineage of his own construct of the psychopath, tracing this back to the pioneering work of Pinel. Cleckley traced the continued development of the concept through Prichard's formulation of moral insanity and the contribution of Rush to the understanding of different degrees of derangement based upon faculty psychology. Cleckley observed that these early commentators emphasised both the presence of:

> "...serious personality disorder" in the absence of any impaired cognitive functioning and also emphasised at the same time that personality disorder should be regarded as an illness "to distinguish it from ordinary crime or depravity" (Cleckley 1976,:226).

Cleckley praised these early attempts to describe personality disorder for their clarity, suggesting that this had been progressively lost, hence his own efforts to re-establish a clearly delineated construct of psychopathy. In the 5th edition of his seminal work published in 1976, Cleckley lamented the fact that the passing of faculty psychology into history had not prevented its concepts entering "by the backdoor":227. The fundamental problem with faculty psychology according to Cleckley is that it regards linguistic constructions "as if they referred to what can be met in experience":227. The reality however is that the body, mind, feeling, thinking, intellect, moral faculty, personality and character "cannot, except in language, be split apart and dealt with as clear-cut entities":228. Cleckley maintained that the tendency to rely excessively upon linguistic constructions, led to "a confusion unparalleled in the whole field of psychiatry":229. This is in keeping with the views of Ellard (1989) previously discussed within this chapter.

Cleckley also identified a tendency to use the category of 'psychopathic' as a reservoir for any diagnosis or anyone that would not fit into other categories; hence the category 'psychopathic' became a "veritable diagnostic salad of incompatibles":229. Echoing Schneider's characterisation of psychopathy as a pathology of the mind (Schneider 1923), Cleckley holds up the term psychopathic personality itself as a prime example of a terminological muddle, given that the literal meaning of the term is such that it can apply to all psychiatric disorders. Cleckley illustrates this by referring to the typology of psychopathic personalities

described by Kahn (1931), in which he lists 16 different subdivisions that are extremely heterogeneous.

Cleckley maintained that the category anti-social personality within DSM-II clearly delineated the archetypal psychopath (Cleckley 1976) as previously described by himself in contrast to DSM-I, which had used a more heterogeneous category of sociopathic personality disturbance, antisocial reaction. Others have since argued that subsequent revisions to the DSM have led to a progressive reduction in clarity exemplified by the increasing conflation of the distinct concepts of antisocial personality disorder and psychopathy (Hart and Hare 1997). Among the practical implications for those who are given a diagnosis of antisocial personality disorder is that inappropriate assessment instruments are more likely to be used increasing the risk of erroneous conclusions being reached (Warren and South 2006). One of the explanations for the tendency to conflate these two different diagnoses is that within DSM-IV-TR, psychopathy is conflated with antisocial personality disorder, hence in describing antisocial personality disorder it is stated that:

> "This pattern has also been referred to as psychopathy, sociopathy, or dyssocial personality disorder":702.

It has been argued that one consequence of this, at least in the USA, has been the over-diagnosis of psychopathy as distinct from antisocial personality disorder among those being processed through the criminal justice system. This in turn has led to harsher sentences being passed,

including the death penalty, on a number of individuals who may well have otherwise received lesser sentences. Part of the rationale for harsher sentencing appears to be the perception of hopelessness associated with any prospect of positive change among those who have been given a diagnosis of psychopathic personality disorder (Hare 1996). The current situation regarding psychopathic personality disorder in particular is therefore one of uncertainty and confusion (Shipley and Arrigo 2001). Against the background of a public safety discourse this has potentially significant implications for those who receive such a diagnosis because: "the constitutional plight of the psychopath is more perilous than that of any other mentally ill individual" (Shipley and Arrigo 2001,:413), in so far as public protection can be used as an argument for the suspension of the rights and liberties of those with this diagnosis. This has clear parallels with the Dangerous and Severe Personality Disorder policy that has been developed in England: this will be explored subsequently within this thesis. The tendency to conflate the diagnosis of antisocial / dissocial and psychopathic personality disorder may shed some light on the policy position that has been maintained in Scotland, of not admitting those with a primary diagnosis of personality disorder into mental health facilities. This will be explored in further detail subsequently within this thesis.

The description of the psychopath provided by Cleckley has a deeply sinister feel: Cleckley states that the fundamental personality defects:

> "...of the psychopath are not covered over by peripheral or surface functioning suggestive of some eccentricity or peculiarity of personality but by a perfect mask of genuine sanity, a flawless surface indicative in every respect of robust mental health" (Cleckley 1976,:253).

This theme was later to be reiterated by those who wished to challenge what they perceived to be construct drift, most notably within subsequent revisions of the DSM (Shipley and Arrigo 2001). In highlighting the need for greater conceptual clarity the 'monstrous' characteristics of the psychopath have often been emphasised. One such account gives the impression of psychopaths as rather like vampires walking among an innocent and unsuspecting population, preying upon them at will:

> "...psychopaths are social predators who charm, manipulate, and ruthlessly plough their way through life, leaving a broad trail of broken hearts, shattered expectations, and empty wallets. Completely lacking in conscience and in feelings for others, they selfishly take what they want and do as they please, violating social norms and expectations without the slightest sense of guilt and regret" (Hare 1993,:xi).

It has been argued (Hart and Hare 1997) that the constructs of psychopathic and antisocial personality disorders, are actually based upon two distinct traditions that differ in their approach to the most appropriate means of arriving at a diagnosis of personality disorde*r*. The first

approach, is based upon a European and certain North American clinical traditions, these are associated with attempts to clearly delineate and describe the construct of psychopathy. This is reflected in the criteria for dissocial personality disorder contained within ICD-10 and is consistent with the approach taken by Cleckley and proponents of his approach including Hart and Hare (Hart and Hare 1997). The second approach is characterised as depending to a greater extent upon:

> "A focus upon behavioural symptoms… to the exclusion of inferred interpersonal and affective symptoms" (Hart and Hare 1997,:23).

This second tradition has influenced the DSM such that matters relating to the construct itself have been relegated to the textual notes within DSM-IV-TR, rather than being expressed within the diagnostic criteria per se. Hart and Hare offer a definition of psychopathy that has strong similarities with Cleckley's original formulation:

> "Interpersonally, psychopaths are grandiose, arrogant, callous, superficial, and manipulative; affectively, they are short tempered , unable to form strong emotional bonds with others, and lacking in empathy, guilt or remorse; and behaviorally, they are irresponsible, impulsive, and prone to violate social and legal norms and expectations" (Hart and Hare 1997,:22).

The precise relationship between the constructs of psychopathy and antisocial personality disorder is far from clear (Warren and South 2006),

despite this however the terms are often used interchangeably. The significance of this (Hart and Hare 1997), is that the approach based upon behavioural factors may lead to the over diagnosis of psychopathy within criminal populations, and under diagnosis in the non-criminal population.

Conclusion

Personality disorder emerged from the concept of moral insanity. Despite certain claims to the contrary, it is reasonable to assert, that moral insanity was not the first description of psychopathic personality disorder but rather that it provided the basis for the development of the diagnostic category of psychopathic and other personality disorders. Personality disorder, from its earliest origins within moral insanity, has served the purpose of providing a mechanism for explaining and categorising particular types of behaviour and thought processes; namely those that are otherwise inexplicable and that represent a perceived threat to normative standards by challenging the boundaries of acceptable attitudes and conduct. The history of the development of the concept of personality disorder is characterised by a tension between a focus upon moral failings and congenital factors that continues to resonate today, this has clear implications for the way that those who may attract this diagnosis are perceived. This will be discussed subsequently in the first findings chapter i.e. chapter 6.

The diagnosis of personality disorder therefore contributes to the regulation of the space between the individual and society, by 'marking out' individuals perceived as representing a particular type of threat to the normative social order. Personality disorder therefore serves the function of allowing members of the virtuous community (Rose 1999) to distance themselves from those perceived as wicked or excessively troublesome, by constructing them as inherently 'defective', and therefore substantially different from the majority of the population: this in turn tends to reinforce the excluded and marginalised status of those who attract a diagnosis of personality disorder. During the 19th century faculties were invented to act as causes to explain behaviour without any substantive explanation of these faculties in terms of their origin, location and qualities (Ellard 1989). More recently the "wheel has turned full circle" (Ellard 1989:129): entities have been transformed into processes and faculties have been transformed into factors that are used to map the human personality. The current constructions of personality disorder within the DSM-IV-TR and ICD-10 classification systems can be viewed to some extend as a return to the source, reflecting Prichard's formulation of moral insanity.

The absence of robust evidence regarding the aetiology of personality disorder means that this diagnosis remains inherently tautological: this will inevitably continue to be the case for as long as the diagnosis is dependent upon the observation of behaviour that in turn is attributed to the presence of a disordered personality. Psychopathy serves as an

exemplar of the tautological nature of the diagnosis of personality disorder:

> "Why has this man done these terrible things? Because he is a psychopath. And how do you know that he is a psychopath? Because he has done these terrible things" (Ellard 1989,:128).

The stigma associated with a diagnosis of personality disorder carries with it substantial implications for the welfare and human rights of those who receive this label. This diagnosis superimposes a particular form of spoiled identity that has a tendency to lead to the individual being perceived in terms of their diagnosis, as distinct from being perceived as a particular individual with unique patterns of need. The incorporation of personality disorder into the definition of mental disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003, carries with it the potential to facilitate appropriate access to services. The alternative possibility however is that this particular measure will simply reinforce the previously identified pattern of exclusion, and a tendency for professionals to respond to those who attract a diagnosis of personality disorder from a public protection perspective to the exclusion of the needs of individual service users. Both of these latter possibilities have the potential to further subordinate and marginalise the needs of those who have been given this form of diagnoses. The contested concepts that underpin the modern diagnostic category of personality disorder are of crucial importance because of the legacy that those who attract this diagnosis are required to inherit. The question of which combination of potential

outcomes is most likely to emerge in the longer term can however only be answered by means of empirical investigation. This will be discussed in the findings section of this thesis.

Chapter 3:

'Law, policy and practice: an historical and comparative analysis of personality disorder within Scotland and England / Wales'

Introduction

The purpose of this chapter is to provide an historical basis for the subsequent analysis of recent developments within the three domains of policy, law and practice for those who attract a diagnosis of personality disorder in Scotland. An analysis of these developments themselves will be provided within the next chapter of this literature review.

The rationale for taking this long view is that "...the past is still active in the present" (Ion and Beer 2003:237); consequently an historical and comparative analysis is required in order to reveal the range of alternative possibilities, interpretations and courses of action open to those responsible for formulating policy, drafting legislation and then implementing these in practice. The analysis offered within this chapter will require consideration of the possible reasons behind the various choices that have been made in the process of formulating policy, law and practice in respect of those who may attract a diagnosis of personality disorder.

The focus of this analysis will be the neighbouring jurisdictions of Scotland and England / Wales. As demonstrated within the first chapter of this literature review, the construct and diagnosis of personality disorder emerged largely from concerns about a particular group who would today frequently, but not exclusively, be classified along the diagnostic continuum of dissocial / antisocial - psychopathic personality disorder. Within the much broader diagnostic category of personality disorder, the diagnosis of psychopathic personality disorder has historically been the main focus for legislators and policymakers due to the administrative imperative of maintaining discipline within institutional settings. The notoriety that has been, and continues to be, associated with those who commit violent crimes who also have been given this diagnosis serves to reinforce this focus further (Peachey 2012). The major focus of this chapter will therefore be that of a historical and comparative analysis of law and practice with what came to be referred to in key documents as the psychopathic group.

The Contested Territory of Personality Disorder

The status of personality disorder, as with other areas of mental health care, is embedded within particular socio-political contexts (Ion and Beer 2003) that have influenced key developments in terms of the direction and content of policy, law and practice. The conceptualisation of any form of mental disorder takes place "within the dynamics of a moral order" (Pilgrim 2005,:437). In his lectures concerning the Abnormal, Foucault

argued that the convergence of psychiatric and juridical discourses between the 18th and 19th centuries resulted in "a new moral economy of punishment" (Ruddick 2006:55). This process formed the backdrop against which mental illness, learning disability and personality disorder emerged as distinct medical and legal entities and continue to be of significance.

The relationship between medicine and jurisprudence was characterised by Foucault as one of struggle and contest, as those within these two disciplines vied for supremacy and to demarcate their particular professional territory (Foucault 1988; Foucault 2003). Foucault maintained that the discipline of medicine succeeded in redefining how crimes committed by individuals should be understood, by shifting the focus away from what an individual had actually done to that of what they might be liable to do. Foucault maintained that the successful development of psychiatry as a discipline, whose members could enjoy relatively high status and exercise power, rested largely upon the extent that its members were able to persuasively claim the ability to be able to predict what individuals might do on the basis of specialised diagnostic methods. These tensions have continued to be of significance with regard to the status of those who attract a diagnosis of personality disorder, coming into particularly sharp focus for example in the recent debate concerning the relationship between dangerousness and diagnosis. This is exemplified by the politically contrived pseudo-diagnosis of Dangerous and Severe Personality Disorder (Pilgrim 2007).

The issue of dangerousness and risk was of particular significance within this territorial dispute between law and medicine, laying the foundation for a preoccupation with risk that was to become increasingly significant throughout social policy (Webb 2006). The significance of this shift of emphasis will be given further consideration in the next chapter. According to Foucault, this shift took place because the emerging discipline of psychiatry perceived dangerousness (Foucault 1988) to be an effective means of securing a bridgehead on the territory traditionally occupied by members of the legal profession. Foucault maintained that particular concepts within psychiatry were developed largely in order to assist this emerging discipline to stake claims and therefore to expand its field of power. From this perspective psychiatry is deemed to rest upon various artifices of discourse. A specific example cited by Foucault is that of the concept of homicidal monomania. In advancing this particular analysis Foucault is asserting a particular type of relationship between knowledge and power, such that claims to have privileged knowledge should also be viewed as attempts to assert power over individuals and groups, including other professions and disciplines (Foucault 1980).

Foucault maintained that once psychiatry had successfully established a role for itself within jurisprudence that the concept of homicidal monomania was strategically jettisoned having served its purpose, thus homicidal monomania:

> "came to act as proof that psychiatry had a key role in public hygiene. Now psychiatrists no longer have to show the link

> between madness and danger, the system of administration presupposes it..... There is no longer any need for monomaniacs" (Foucault 2003:142).

The association of dangerousness and mental disorder has persisted and is one factor that has influenced recent developments within the three domains of policy, law and practice. The precise role of dangerousness in influencing key developments within these domains will be discussed within the next chapter of this literature review.

The historical development of policy, law and practice in respect of those diagnosed as being mentally disordered, has been strongly influenced by concerns regarding the threat that they are perceived to represent in terms of their inherent dangerousness and their alleged degenerative potential for society as a whole. On occasion these issues became conflated such that particular individuals and groups were perceived as dangerous because of their degenerative potential. A further significant influence on developments within these three domains can be broadly characterised as an administrative or managerial imperative; this is clearly evident within a number of reports that will be discussed within this chapter. These themes will now be explored further within the following historical and comparative analysis.

Key Historical Debates: Evidence from Commissions, Reports and Inquiries

The legal status of personality disorder has and continues to be contentious. There are two principal explanations for this. The first concerns whether or not it is actually necessary or useful to specifically incorporate personality disorder within statute law as a designated category. Debate concerning this point tends to centre upon issues of control and treatment - most notably the control and treatment of those 'diagnosed as dangerous', exemplified by responses to those who attract a diagnosis of psychopathic personality disorder. The second concerns the on-going debate involving philosophical and practical questions relating to the status of personality disorder within the diagnostic lexicon of psychiatry; these have been explored within the first chapter of this literature review.

The debate concerning whether or not to include a distinct category of personality disorder within the law has been significantly influenced by an administrative imperative. In respect of law and policy in the United Kingdom historical debates concerning if and how this group should be included within mental health legislation can be traced to the deliberations of the Royal Commission on the Care and Control of the Feebleminded (1908) Chaired by Lord Radnor. This commission considered the merits of including a distinctive group within the law for the morally insane, which as demonstrated within the previous chapter of this literature review, can be understood as referring to what would later become known as personality disorder and antisocial / psychopathic personality disorder

somewhat more specifically. The commission rejected the suggestion that such a group should be explicitly recognised in law on the basis that it would be "scientifically incorrect" (Walker and McCabe 1973:210) to do so. This decision reflected the contested nature of moral insanity. The Radnor Commission did however acknowledge the existence of particular difficulties associated with a specific subgroup within the prison population: this group were regarded as representing a distinct challenge to administrators, on the basis that they were highly resistant to the deterrent effects of incarceration and tended to undermine efforts to maintain good order within institutional settings.

The minutes of evidence given to the Radnor Commission also reveal the significance of eugenic anxieties concerning the perceived relationship between population degeneration, mental illness and crime. This echoed the previous work of Kraepelin (Hoff 1998) and earlier writers such as Morel and Megan. These general concerns led to a more specific focus on women who were perceived to be mentally disordered, on the grounds that they represented a special type of threat to society by means of their reproductive potential. The particular focus upon women can also be seen as part of a continuation of a more established "discourse of bastardy" (Carabine 2000:84) in which the reproductive capacity of women, particularly women without the means to provide for their children, have been characterised as representing a particularly pernicious threat to the social order based upon fears of widespread moral corruption. These concerns were given particular expression within the New Poor Law 1834 and the Poor Law (Scotland) Act 1845 (Blaikie 2005).

Certain evidence given to the Radnor Commission illustrates the convergence of eugenic concerns about population degeneration and mental disorder. This is representative of a particular discourse of "degenerationism" (Lucklin 2006:237) that constituted a distinct theme within the broader discourse of eugenics. Degenerationism was particularly concerned with the urban working class, who came to be perceived as an inherently problematic population during the mid to late 19th century. Within this discourse poor working class women were given particular attention as they were deemed to represent a distinct threat due to their reproductive potential. The discourse of degenerationism can be seen as part of a wider process of "othering" large sections of the population "by marking them as deviant, criminal, psychotic, defective, simple, hysterical, diseased, primitive, regressive, or just dangerous" (Lucklin 2006:237). Women became a particular focus of attention due to the conflation of poverty, madness and danger.

In expressing concerns regarding women from the "defective class" while giving evidence to the Radnor Commission (para 754), a Home Office Inspector under the Inebriates Acts, namely a Dr Braithwaite provided the following observation:

> "Being women, and not under control, they go to swell the immoral classes" (para 755).

The tendency towards objectification becomes distinctly clear by the use of the term "average specimen" (para 792) in describing a person said to

be representative of this group. This exchange also contains an example of the common usage at the time of the term moral defective, being used to describe a boy of whom it is said: "I do not think we shall ever get him to have any sense of right or wrong" (para 816). The tendency towards the objectification and dehumanisation of members of this group or class, is highlighted by a comment contained in a reply by a witness in describing the so-called morally defective as particularly vulnerable to "animal instinct" (para 857).

The minutes of the Royal Commission described above contain clear evidence of the established association between dangerousness and so-called 'defectives'. The meaning of dangerous was clarified during the course of evidence being taken from the aforementioned Dr Branthwaite, during which a question put by a member of the commission described the defective class as "dangerous to society" (para 754), both due to their tendency towards violence and their reproductive capacity. These eugenic-based anxieties influenced policy developments and the drafting of legislation in both jurisdictions: this is evident within the parallel Mental Health Acts of 1913 enacted for both jurisdictions (Darjee and Crichton 2003).

The minutes of this Royal Commission contain an expression of eugenic anxiety that was exemplified in a publication by the socialist writer Jack London in '*The People of the Abyss',* in which the population of the East End of London are described in lurid terms as:

> "...a fearful slime that quickened the pavement with life… a menagerie of garmented bipeds that looked something like humans and more like beasts".

London goes on to say of the people he observed that:

> "They reminded me of gorillas. Their bodies were small, ill-shaped, and squat….. They exhibited… an elemental economy of nature, such as the caveman must have exhibited".

London clearly associated his observations of the physical characteristics of the people he observed with psychological characteristics such that he stated:

> "They possess neither conscience nor sentiment and they will kill for a half-sovereign, without fear or favour, if they are given but half a chance. They are a new species, a breed of city savages… The slum is their jungle and they live and pray in the jungle" (London 1903: 324-5).

The analysis offered by Jack London of the cause of this apparent degeneracy stands in stark contrast however to the moral degeneracy arguments being more generally advanced at that time. London argued against the notion that this group of the population were inherently inferior, asserting instead that their condition could more properly be

attributed to their prolonged exploitation and oppression, leading to their impoverishment not just financially but physically and intellectually.
The report of the Royal Commission (Darjee and Crichton 2003) provided the basis for the subsequent introduction of parallel legislation in Scotland and England / Wales in the form of the Mental Deficiency and Lunacy (Scotland) Act 1913 and the Mental Deficiency Act 1913. This legislation represents an example of convergence and concordance between the two jurisdictions, with both Acts containing the same definitions and categories i.e. idiots, imbeciles, feebleminded persons and moral imbeciles; the moral imbecile is specified in part 1 of both Acts namely:

> "...persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little effect" (1) (d).

The Mental Deficiency and Lunacy (Scotland) Act 1913 is of particular significance therefore because it contains the foundation for the detention of those who might later be classified as psychopaths, although this group is not explicitly acknowledged (Crichton 2001).

The association of women, immorality, poverty and crime as a threat to the social order not only predated legislative reform at the beginning of the 20th century but continued to have a strong resonance thereafter. Evidence for this can be found in the underclass thesis popularised by Charles Murray, in which the association between the purported growing and menacing underclass and female reproduction, specifically giving

birth to illegitimate (sic) children, are characterised as fuelling violent crime. In purporting to identify the emergence of a British underclass, Murray provides two sets of statistical data relating to single motherhood and crime, thereby implying a causal relationship between the two namely: the number of births to single women as a percentage of the total number of births and crimes of violence per 100,000 population (Murray 1996). The continuing significance of this perspective can be found in recent comments about the threat to the 'human stock' as a result of too many mothers from poor backgrounds having children (Watt 2010).

The Treatability Criterion - Safeguards and Responsibility

The Radnor Commission recommended the inclusion of an age criterion to operate as a constraint on the use of compulsory treatment; this recommendation was accepted and incorporated within the two Acts of 1913. The rationale for this treatability criterion was the belief that those aged over 21, were much less likely to be susceptible to and therefore benefit from treatment. In the case of Scotland feebleminded persons and moral imbeciles over 21 could only be "placed under care as a certified mental defective ... by Order of the Sheriff" (Russell 1946:64). These criteria were to remain in force until the introduction of an alternative treatability criterion contained within the Mental Health Act 1983 and the Mental Health (Scotland) Act 1984, the significance of which will be discussed subsequently.

Following the legislative concordance achieved within the parallel legislation of 1913, divergence if not discordance was to be introduced by the Mental Deficiency Act (1927). This legislation that did not apply to Scotland, was passed in response to concerns about a lack of definitional clarity within the Mental Deficiency Act (1913): this Act redefined the category of the moral imbecile and made it one of the four subcategories of mental defective (idiots, imbeciles, feeble minded and moral imbeciles). Reference to the ineffectiveness of punishment and deterrence was removed such that the new category contained in s. 1 (1) (d) simply read:

> "Moral defectives, that is to say, persons in whose case there exists mental defectiveness coupled with strong vicious or criminal propensities and who require care, supervision and control for the protection of others".

The report Protection and Training (Scottish Office, 1928), called for the adoption of the approach contained within the Mental Deficiency Act 1927 on the grounds that this would bring greater clarity to the law in Scotland: this recommendation was however not taken up. The rationale behind the recommendation is detailed within this report as follows:

> "The *moral imbecile* of the Act is elusive. Facts and figures show that doctors seldom agree as to who he is and how he should be dealt with. The definition, indeed, is obscure and open to many

conflicting interpretations. Its most serious weakness, however, is that it makes difficulties where it was meant to be helpful" (p 29).

The report also highlighted the importance of the question of capacity and by implication the diagnosis of personality disorder in stating that:

"By its unhappy use of the word "imbecile", which suggests a very marked defect of intelligence, it hampers the Judge when he has to deal with a prisoner who has a pronounced moral defect, though in intelligence he may be almost normal. The definition calls for immediate alteration" (p 29).

Evidence of a continuing anxiety based upon eugenic considerations can also be found within the same report in the recommendation that certain key provisions contained within the Mental Deficiency and Lunacy (Scotland) Act 1913 should be retained:

"We were particularly impressed with the necessity of shielding the mentally defective girl, sometimes herself handicapped by excessive sexual desire, always the easy prey of the unscrupulous and unprincipled. Section 3 (1) (vi) of the Act provides that a defective unmarried woman shall be "subject to be dealt with" if she is in receipt of poor relief at any time during her pregnancy or at the time of giving birth to a child, but, according to evidence, the sub-section is not made use of. Such women who have given birth to children in a poorhouse are allowed to leave almost at once. It is

> manifest that the sub-section should be enforced with the utmost vigilance, in the interests both of the women themselves and of the community" (p 35).

Despite minor amendments to the law in Scotland introduced by the Mental Deficiency (Scotland) Act 1940, the category of moral imbecile retained its place within Scottish legislation until the Mental Health Act 1960 (Darjee and Crichton 2003).

Concern regarding the administrative difficulties caused by a particular subgroup, who would fall within the diagnostic spectrum of dissocial / antisocial personality disorder, psychopathy and currently in the case of England DSPD, was further identified in the report of the committee on the Scottish Lunacy and Mental Deficiency Laws (Russell 1946). This report referred to a separate and distinct "class of persons" who were not clearly enough demarcated within the existing definitions of feebleminded, imbecile, idiot and moral defectives, thereby echoing the views discussed above expressed within Protection and Training 1928. The Russell Report described this subgroup as consisting of those:

> "...who display distressing symptoms of unstable, disordered behaviour, and are regarded as social misfits but whose mental capacity and conduct touch only the fringe of insanity or mental defectiveness or criminality. For this type no suitable treatment appears to exist and in the great majority of such cases it seems to be the view that they are not appropriately certifiable in any sense,

> nor suitable for prison treatment. It occasionally happens, however, that certain of them are certified as mentally defective or insane and are sent to institutions where they prove to be a constant source of difficulty and trouble to themselves, to those supervising their training, and to their fellow inmates in these institutions" (para 426, italics as per the original).

The Russell Report (1946) quoted from the report of the Radnor Commission in respect of this particular subgroup describing them as being:

> "...committed to prison for repeated offences which, being the manifestations of a permanent defect of mind, there is no hope of repressing, much less stopping, by short, punitive sentences" (para obtain 344).

The report contained the recommendation that special provision be made for this group in terms of long-term psychological treatment with a view to allowing them to be returned to society as useful citizens (Russell 1946). The 'problem' of how to cope with this particular subgroup resulted in a boundary dispute between law and medicine, reminiscent of Foucault's observations (Foucault 1988; Foucault 2003) concerning the early history of psychiatry. The issue was brought into focus by the question of the proper grounds for a finding of diminished responsibility. In the case of Carraher, Lord Normand (1946) rebutted what he clearly

perceived to be an attempt by the profession of medicine to encroach upon the proper territory of the law stating that:

> "The Court has a duty to see that trial by judge and jury according to law is not subordinated to medical theories; and in this instance much of the evidence given by the medical witnesses is, to my mind, descriptive rather of a typical criminal than of a person of the quality of one the law has hitherto regarded as being possessed of diminished responsibility".

These comments echo the concerns previously identified within the report of the Departmental Committee on Persistent Offenders (1932) referred to above. According to Foucault, (Foucault 1988) clear evidence can be found for the legitimacy of concerns by the judiciary, regarding the aspirations of certain of those within the medical profession to expand their sphere of influence and ultimately to usurp certain functions and powers of the court. This tension is exemplified by the assertion that experts should become the judges of the Judges. Referring to a meeting of the Criminal Anthropology Association (1889) Foucault quotes Pugliese as asserting:

> "The commission of medical experts to whom the judgment ought to be referred should not limit itself to expressing its wishes; on the contrary it should render a real decision" (p 145).

Continuing tension can be found between the professions of medicine and law in the report of the Royal Commission on Capital Punishment (1953). This report contains criticism of the lack of conceptual clarity and agreement among psychiatrists regarding the term moral imbecile; the problem being that the term implied a degree of impaired intelligence and rationality that was generally not found within this particular group. The commission particularly criticised the definition of moral defective, referring to English / Welsh legislation in the form of the Mental Deficiency Act 1927 as being out of date on the basis that the phrase contained within the legislation: "there exists mental defectiveness coupled with strong vicious criminal propensities", should be understood explicitly as referring to those liable to attract a diagnosis of psychopathic personality disorder stating that:

> "Such persons would nowadays usually be regarded as cases of psychopathic personality" (para 358).

The phraseology contained within the legislation being referred to, is so similar to that contained within the then current Scottish law based upon the Mental Deficiency and Lunacy (Scotland) Act 1913, that this criticism can be regarded as equally relevant to both jurisdictions. The observation made by the commission is also important because it removes any doubt that the original phraseology contained within the parallel legislation of 1913 was attempting, albeit imprecisely to describe those who would otherwise probably attract a diagnosis of personality disorder or more specifically a diagnosis of psychopathic personality disorder.

This Royal Commission heard evidence relating to psychopathic personality disorder and the lack of definitional clarity. The report contains a conclusion that echoes the criticism made by Lord Normand described above:

> "There is no generally accepted definition of this term, and no consensus of opinion about the scope or the nature of the mental condition which it is intended to describe. It is sometimes used in so wide and loose a sense as to justify the observation of an American commission that it has "been used for many years as a convenient psychiatric waste-basket for cases otherwise difficult to classify". Even when it is more narrowly and strictly employed, the character and conduct of those to whom it is applied, in the courts and in penal institutions, are often such that it is natural for the layman to feel that they are typical of a confirmed criminal or simply of wicked men rather than an indication of mental disease or aberration, and to doubt whether the term has any scientific validity" (para 393).

The commission's report also notes that evidence was received from Sir David Henderson a leading Scottish psychiatrist:

> "...that it was wrong, and indeed a complete travesty of justice, that anyone who could be certified under the Mental Deficiency Acts-even a comparatively high-grade defective, such as a feeble-

minded person-should be regarded as fit to plead and to stand his trial" (para 342).

This view however was ultimately discounted by the commission on the basis that:

> "This view was not supported by any other witnesses, and we are unable to accept the far-reaching suggestion that every person who is certifiable as a mental defective must necessarily be regarded as unfit to stand his trial" (para 342).

An example of legislative convergence and concordance between the two jurisdictions can be found in the Homicide Act 1957. This Act introduced into statute law throughout the United Kingdom the doctrine of diminished responsibility that had been previously developed within Scotland, as described by the Royal Commission on Capital Punishment (1953).

Within this same year a further significant opportunity for additional convergence resulted from the recommendations of The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, commonly referred to as the Percy Commission (1957). This commission recommended that three groups of patients be identified within mental health legislation, including a distinct group for those who attract a diagnosis of psychopathic personality disorder. The rationale for this

appears to have been at least in part due the administrative imperative described above; the commission therefore recommended:

> "...that for these broad administrative purposes three rather than two main groups of patients should be recognised……. We consider that in the General Administration of hospital and community services, and in connection with compulsory powers, the higher-grade feebleminded and moral defectives and other psychopathic patients should be recognised as together constituting one main group of mentally disordered patients, the other two groups being the mentally ill and the severely sub-normal" (Part 3,para 187).

The commission recommended that three categories should be adopted within a new legislative framework namely:

"Mentally ill patients: this would include mental infirmity due to old age and would replace the term *person of unsound mind*, which should no longer be used.
Psychopathic patients, or patients with psychopathic personality: including a special subcategory of feebleminded psychopath, for those psychopaths suffering from impaired intelligence but who would not fall into the category of severely subnormal.
Severely sub-normal patients, or patients with severely sub-normal personality: this was intended to include those previously classified as idiots and imbeciles together with some who would also then have been labelled feebleminded".

Part of the rationale for the commission's proposals was that of limiting the use of compulsory measures to circumstances in which it was strictly necessary (para 135). The Dunlop Committee however subsequently made use of this same rationale in its rebuttal of the recommendations of this Royal Commission; the significance of this rebuttal will be discussed more fully subsequently.

In its report the commission went to some considerable length to emphasise the importance of definitional clarity, illustrating this by referring to the Statute de Praerogativa Regis, thought to date from the 14th century containing a crucial distinction between lunatics and idiots:

> "This statute asserted the wardship of lunatics and idiots and of their property to be a prerogative of the Crown" (p 44).

The distinction was of very great significance to the person concerned because the property of lunatics had to be preserved intact in order to be returned upon recovery, it being lawful only to deduct from their property enough to cover the maintenance of the lunatic and his family until s/he had recovered. In the case of idiots however it was lawful for the Crown or the person into whose care the idiot had been entrusted to permanently appropriate all of the funds from any estate beyond that necessary to pay for the maintenance of the person concerned.
In its report (Part 3, para 156) the commission refers back to the previous Royal Commission report of 1908, which had emphasised the need for a particular definition that appears to equate with the diagnosis

of personality disorder, or specifically antisocial or psychopathic personality disorder: namely one that included those whose intelligence was unaffected by their mental abnormality and who represented a danger to others. The Royal Commission of 1957 concluded that this recommendation had formed the basis for the definition of the Moral Imbecile contained within the parallel legislation of 1913.

The report of the Royal Commission published in 1957 contains an important distinction between rights and necessity vis-à-vis the protection of others, this foreshadowed the form of words subsequently to be used within the emergency legislation: the Mental Health (Public Safety and Appeals) (Scotland) Act (1999) and carried over into the Mental Health (Care and Treatment) Act (2003): these two pieces of legislation will be discussed within the next chapter of this literature review. In paragraph 317 (d) of the report of the Royal Commission, the following distinction appears concerning the use of compulsory powers to admit a person for treatment; that there must be a:

> (i) good prospect of benefit to the patient from the treatment proposed-an expectation that it will either cure or alleviate his mental disorder or strengthen his ability to regulate his social behaviour in spite of the underlying disorder, or bring him substantial benefit in the form of protection from neglect or exploitation by others;
> or (ii) a strong need to protect others from anti-social behaviour by the patient.

This second provision amounts to a recommendation in favour of the use of compulsory measures even when there is no prospect of direct benefit to the patient: this is consistent with the measures introduced within the emergency legislation referred to above.

In specifically considering the treatment of those within the so-called psychopathic group the Commission however recommended the use of an age based criterion to act as a constraint on the use of compulsory powers. This recommendation was based upon evidence heard by the commission concerning the relationship between treatment effectiveness and age. The commission recommended that the age of 21 years should be established as the cut-off point for the use of compulsory powers, for the admission of someone to hospital or guardianship, based upon a diagnosis of psychopathic personality disorder. This echoed the recommendations of the Royal Commission of 1908. An additional safeguard was also recommended: namely that any compulsory measures should lapse in the case of anyone admitted under the age of 21, when they reached the age of 25 if they had not already been discharged:

> "Compulsory admission to hospital guardianship for a longer period of hospital or community care should be allowed for patients under the age of twenty-one at the time of admission if this is necessary for the patient's own welfare or for the protection of others. The compulsory powers should lapse when the patient reaches the age of twenty-five if he has not already been discharged, unless

admission followed court proceedings or transfer from prison or approved school" (Ch 7, para 367, (ii)).

The next paragraph (iii) introduces an important distinction between those who had been convicted of an offence and those who had not. The report contains a recommendation that compulsory admission to hospital or guardianship should be used for those with a diagnosis of psychopathic personality disorder who were over the age of twenty-one and who had been convicted of a criminal offence; where the court is satisfied that ordinary penal measures alone would not be appropriate, or upon the decision of the Home Secretary in the case of transfers from prison. The emphasis upon detaining those who attract this form of diagnosis, only if they had been convicted of an offence stands in marked contrast to the debate that was to emerge towards the end of the 20th century, this will be discussed subsequently.

The commission acknowledged what it regarded as a fundamental definitional problem taking the form of a tautology, by recognising that:

> "The treatment and the use of compulsion must be based on a medical diagnosis of the individual patient's mental condition, not merely on evidence of his behaviour. The difficulty is that with patients in the psychopathic group it is their behaviour which provides the main evidence of their mental condition" (para 339).

The Scottish Rebuttal

The Dunlop Committee having been established to consider the relevance of the findings of the Royal Commission of 1957 to the law in Scotland delivered a resounding and somewhat contemptuous rejection of the commission's recommendation in favour of explicitly including a distinct psychopathic group within mental health law. The committee gave the following reasons for rejecting the incorporation of a specific psychopathic group within Scottish legislation, namely that:

> (a)" The term psychopathic has already come to have so many meanings that it has almost no medical significance. The introduction of yet another meaning would add to the confusion already existing" (Dunlop 1958,:para 7).

The committee also argued that the problem of stigma would not be satisfactorily addressed by formally recognising this group. The committee did however accept the existence of the so-called psychopathic group, choosing instead to emphasise the importance of treatability and argued that those who were likely to benefit from psychiatric treatment were also likely to fall within the existing legal definitions. This position seems to be based implicitly on the idea of comorbidity with the personality disorder component being assumed to be untreatable. The committee also appears to have been concerned that the inclusion of the so-called psychopathic group would lead to a greater use in compulsion; this was felt to be undesirable and contrary to the stated intentions of the

Royal Commission itself. This observation by the committee proved to be somewhat prophetic. Data available for England / Wales indicates that following the Mental Health Act 1959, which reflected the recommendations of the Royal Commission of 1957, that within the first year a 100% increase took place in the number of compulsory admissions to hospital. This increase in compulsory admissions was despite the fact that the powers within this new Act corresponded closely with those contained in its predecessor of 1913. One of the reasons for the increase would appear to be that psychiatrists found the definitions within the latter piece of legislation easier to satisfy "and certainly this was intended where psychopathy was concerned" (Walker and McCabe 1973:73). It is noteworthy that no such increase occurred within Scotland following the implementation of the Mental Health (Scotland) Act 1960 (Elliott, Timbury et al. 1979). This should not be taken to mean however that within Scotland patients with a primary diagnosis of personality disorder were not being admitted for treatment; on the contrary clear evidence exists that patients with a primary diagnosis of personality disorder were being admitted to the State Hospital in the 1960s and 1970s (Darjee and Crichton 2003).

To name or not to name - the innominate and nominate inclusion of personality disorder

The desire for legislative concordance, from certain quarters at least, between these two jurisdictions proved to be particularly significant. The

Mental Health (Scotland) Act 1960 did not explicitly replicate the Mental Health Act 1959 that reflected the recommendations of the Royal Commission of 1957 by including a distinct psychopathic group. However the Scottish legislation did incorporate the psychopathic group de facto under the grounds for detention within s. 23 (1) (b), thereby establishing an approach that would be replicated within the subsequent Mental Health (Scotland) Act 1984. The rationale for the de facto, rather than explicit incorporation of the psychopathic group within Scots law, can be found within the deliberations of the Scottish Standing Committee (1960) established to consider the draft Bill that was subsequently to become the 1960 Act. In giving evidence to the committee in respect of the psychopathic group the Solicitor-General for Scotland explicitly stated that the intention of the draft Bill vis-à-vis the Mental Health Act 1959, was to ensure "that the result is almost entirely the same in both cases" (p 368).

It is clear from the minutes of the committee that certain members were uncomfortable with what could be perceived as a deception, for example a Dr Mabon argued that: "we do not think people should pretend things are what they are not" (p 365). The committee was quite clear that the effect of the wording of the draft Bill would be to ensure: "That means in practice that there will be a psychopathic group, although we may not call it that" Dr Mabon (p 365). This committee member also highlighted the logical flaw of categorising all those who may be diagnosed with psychopathy as though they were violent or otherwise dangerous to others. Dr Mabon argued that it was not appropriate to restrict individual liberty on the basis of a diagnosis in the absence of the commission of an

offence: the doctor illustrated the error of logic in this approach with the following example:

> "All lemons are yellow, but not all yellow things are lemons":384.

This was part of a wider argument advanced by this committee member against special measures for those within the so-called psychopathic group that would have effectively amounted to preventive detention:

> "We cannot have a special criminal code for those labelled by the medical profession as psychopaths, because they have not committed a crime. Nor can it be seriously argued that they are bound to do so. That is the kernel of the argument":384.

This committee therefore implicitly discussed the question of preventive detention specifically with regard to those who would fall within the diagnostic circumference of the so-called psychopathic group; this foreshadowed the debate that was to take place subsequently concerning so-called Dangerous and Severe Personality Disorder: this will be examined within the next chapter. An alternative view in favour of preventive detention is clearly implied in a question raised by one of the committee members a Mr Willis: "Are we to wait until such a person commits a serious crime… before we detain him?" (p 377). This committee proved to be influential in amending the draft Bill in accordance with the argument advanced by another committee member, Mr Bruce Millan who maintained that the previous position concerning

treatability and compulsion should be retained, asserting that compulsory measures should only be used if a disorder: "requires or is susceptible to medical treatment" (p 444); the draft Bill was amended accordingly. This amendment was to become of great significance as it was carried forward into subsequent mental health legislation and further expanded within the Mental Health (Scotland) Act 1984. It would prove to be a foundational step on the road that would lead to the landmark ruling in the case of Noel Ruddle, this will be subsequently discussed.

The provision allowing for the detention of those caught by the diagnosis of psychopathy and who were over the age of 21 and convicted of a criminal offence came into effect in both jurisdictions in the Mental Health Act 1959 and the Mental Health (Scotland) Act 1960. The same specified versus unspecified distinction however appears once again. Within the 1959 Act, part 5, s 60 (1) (a) (i) specifically authorises the detention of offenders who meet the criteria for mental illness, psychopathic disorder, subnormality or severe subnormality, providing that the court is satisfied that the disorder is sufficient to merit the offender's detention in hospital and that this is the most suitable way of disposing of the case.
The Scottish legislation does not use the term psychopath but clearly identifies this group by using the following form of words contained within part, 4, s. 55 (1)

> "...the court is satisfied... that the offender is suffering from mental disorder of a nature or degree which, in the case of a person under

twenty-one years of age would warrant his admission to a hospital or his reception into guardianship under Part IV this Act"

The reference to a person under 21 years of age is a reference to the unspecified psychopathic group embedded within the previous legislation. Evidence of this can be found by comparing the two Acts. The definition of psychopathic disorder contained within the 1959 Act Part 1, s. 4, (4) is as follows:

"...means a persistent disorder or disability of mind (whether or not involving subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment".

As with the Mental Health Act 1959 the Mental Health (Scotland) Act 1960 specifically excluded the admission of those with a diagnosis of psychopathy who were over the age of 21. The term psychopathic was not explicitly stated in keeping with the recommendations of the Dunlop Committee.

Part 4, s 23 (1)

"A person who is suffering from any mental disorder that requires or is susceptible to medical treatment may be admitted to a hospital or received into guardianship in pursuance of the appropriate application under the following provisions of this Act; but without

prejudice to the said provisions so far as relating to emergency admission, no person over the age of 21 years shall be admitted or received except where the mental disorder for which he suffers-

(a) is mental deficiency such that he is incapable of living an independent life or of guarding himself against serious exploitation; or

(b) is a mental illness other than a persistent disorder which is manifested only by abnormally aggressive or seriously irresponsible conduct" (My emphasis).

S 23 (1) (b) therefore contains the same phraseology that underpins the definition of the psychopathic group used within the Mental Health Act 1959. It is clear that the same group is being described; although the use of the term psychopathy or psychopath has been avoided in the Scottish Act.

The significance of the age of 21, also being the age specified within the 1959 Act i.e. Part 4, s. 26 (2)(a)(ii) based upon the findings of the Percy Commission, see above, is documented in clear terms within the minutes of the Standing Committee considering the draft Bill that was to become the Mental Health (Scotland) Act 1960.

In other words the 1960 Act contains an unspecified psychopathic group subject to the same exclusionary clauses contained within the equivalent English legislation that contains a specifically identified psychopathic group (Darjee and Crichton 2003).

The 1960 Act contains three criteria that must be satisfied to allow for compulsory detention. After stating that evidence is required from two medical doctors the following criteria are specified within Part 4, s.24 (2):

> "(a) a statement of the form of mental disorder from which the patient is suffering, being mental illness or mental deficiency or both;
> (b) a statement that the said disorder requires or is susceptible to medical treatment and is of the nature or degree which warrants the patient's detention in a hospital for such treatment; and
> (c) a statement that the interests of the health or safety of the patient or the protection of other persons cannot be secured otherwise than by such detention as aforesaid" (My emphasis).

These treatability criteria were to be subsequently strengthened within the Mental Health (Scotland) Act 1984 in keeping with the Mental Health Act 1983, in part to compensate for the removal of the age exclusionary criteria of 21 years.

Dangerousness and Diagnosis

The Butler Report (1975) was established to review the law relating to mentally abnormal offenders in England and Wales. In keeping with the general approach of trying to maintain concordance between the two jurisdictions, it is stated that a representative was made available from

the Scottish Home and Health Department: "who attended our meetings in the role of observer and adviser on Scottish law and practice" (para 1.2). The significance of public concern regarding the treatment and management of those who commit serious offences after being released from custody, was acknowledged by this committee as a significant factor influencing the political climate in which policy had to be framed. To illustrate this specific mention is made of the cases of Graham Young and Terence Iliffe, who had committed very grave premeditated offences involving multiple victims. Both were originally sentenced to imprisonment rather than detention in a Special Hospital because medical witnesses concluded that they were not suffering from a medical disorder that would be susceptible to treatment, Chapter 4 (4.1).

The committee made use of this example to enter into a sophisticated discussion of the concept of dangerousness that bears a close resemblance to that contained within the MacLean Committee report; this will be discussed in the following chapter:

> "Dangerousness depends in the majority of cases not only on the personality of the potentially dangerous offender but also on the circumstances in which he finds himself. The practice of referring to some individuals as "dangerous" without qualification creates the impression that the word refers to a more or less constantly exhibited disposition, like left-handedness or restlessness……. the individual who spontaneously "looks for a fight" or feels a need to inflict pain or who searches for an unknown sexual victim is

> fortunately rare, although such people undoubtedly exist. Only this last category can justifiably be called "unconditionally dangerous"" (Butler 1975, para 4.5).

The committee were therefore taking a strong position against a simplistic and essentialist definition of dangerousness. This nuanced approach is also exemplified by referring to the "trigger effect" or situational factors that are likely to increase the risk of an individual re-offending (Butler 1975) (4.6).

After hearing evidence regarding how dangerousness might variously be understood, the committee decided upon the following definition:

> "...to equate dangerousness with a propensity to cause serious physical injury or lasting psychological harm" (Butler 1975, para 4.10)

This is a surprisingly modern definition and consistent with the current dual focus upon physical and psychological harm caused by violent and sexual offenders in particular (Kemshall 2002; 2004) and is also consistent with advice issued by the Sentencing Guidelines Council (2004).

The committee also recognised the inherent uncertainty of risk assessment processes:

> "In deciding what to do about dangerousness the impossibility of certain prediction is the central problem" (Butler 1975, para 4.11)

This same paragraph then continues with a discussion of the limitations of actuarial approaches, foreshadowing the debate that was later to take place concerning dangerous and severe personality disorder and preventive detention. The committee highlighted the process by which an individual is assigned to a particular probability group, emphasising that it is never possible to predict whether an individual will reoffend based on their membership of any particular group. As this discussion continues into the next paragraph it has a remarkable resonance with the conclusions reached by the MacLean Committee, relating to the process of risk assessment and the rationale behind the recommendation in favour of the Order of Lifelong Restriction underpinned by the process of structured clinical risk assessment:

> "Recognising the limitations of objective assessment, is it better to rely on a continuing process of treatment and subjective assessment in which checks and adjustments are constantly made in the light of the developing pattern of behaviour evinced by the individual concerned? Unfortunately, subjective judgment, based on however much experience, professional knowledge and available information, and exercised however conscientiously, is inescapably unreliable" (Butler 1975, para 4.12).

The committee then went on to highlight the potential dangers to liberty that might follow from an excessive preoccupation with risk (Buchanan and Leese 2001; Pilgrim and Rogers 2003). Regarding dangerousness and detention:

> "In deciding whether society requires more protection, the question has to be faced: how many probably safe individuals should cautious policy continue to detain in hospital in the hope of preventing the release of one who is still potentially dangerous?" (Butler 1975, para 4.13).

By way of illustration the committee highlighted the Baxstrom debacle that occurred in New York State. Baxstrom had been found to be insane while serving a criminal sentence and was subsequently transferred to a State institution for insane criminals. His sentence expired in December 1961; however he was detained in the institution that he had been transferred to previously under provisions of the Correctional Law. In February 1966 the Supreme Court ruled that the law permitting his continued detention was unconstitutional: consequently Baxstrom together with all others similarly detained were entitled to be released. The scale of the apparent *problem* was immense given that between March and August 1966, 969 patients were transferred from Correction Department hospitals to civil hospitals. The significant point is that disaster did not follow:

> "The receiving hospitals it was said quickly found that the Baxstrom cases were indistinguishable from the generality of their patients. Yet all these patients had previously been denied transfer by experienced psychiatrists from the Department of Mental Hygiene on the grounds that they were too disturbed or potentially dangerous" (Butler 1975, para 4.14).

By the end of February 1967, 147 patients had been discharged back into the community, with only seven being regarded as sufficiently problematic to justify judicial commitment to a specialist secure facility. By the end of 1967 there was only one record of an arrest of those who had been released and that was for a minor theft. Subsequent follow-up confirmed the relatively low rate of reoffending amongst this group of patients.

The Butler Committee considered many of the same issues that are current in the debate regarding so-called dangerous and severe personality disorder (DSPD). This was considered in detail by the MacLean Committee (MacLean 2000) in focusing on what to do with violent and sexual offenders who may also be mentally disordered. This issue will be considered in detail within the next chapter. The Butler Committee identified three alternative possible strategies (Butler 1975, para 4.36):

> "(a) arrangements might be made for identifying dangerous mentally disordered prisoners in prison and for determining , towards the end of

their sentence, the necessity for their further detention, under new statutory provisions, in the interests of public safety; or
(b) provision might be made to enable the court to impose an indeterminate sentence at the outset, where it is likely that the offender will pose a continuing threat to society; or
(c) there could be various arrangements based on combining determinate sentences with licensing after normal release at the end of the sentence, taking into account remission - as distinct from parole licensing before the end of the sentence".

The Butler Committee came down in favour of the second option rejecting the third, apparently on the grounds that it would contravene natural justice; although this term is not used:

> "The proposal has been rejected by the Criminal Law Revision Committee on the grounds that it would be unacceptable for a person who had been released after serving a determinate sentence imposed by a court to be recalled to prison by administrative action and detained there perhaps for the rest of his life. The committee pointed out that there is a significant difference between recall as applied in the case of a life sentence prisoner, whose release on licence is a benefit not guaranteed by his sentence, and recall of a prisoner who has already served the determinate sentence imposed at his trial" (Butler 1975, para 4.38).

A similar legislative change to that proposed by the Butler Committee was ultimately enacted within England via the Criminal Justice Act 2003. This Act saw the introduction of indeterminate sentences for offenders meeting certain criteria based upon dangerousness. The option that the Butler Committee rejected however had certain similarities with the Order of Lifelong Restriction introduced within the Criminal Justice (Scotland) Act (2003), this being based upon a punishment element followed by a whole life licence. This provides an example of a divergence of approach in pursuit of the same objective within these two jurisdictions.

The Butler Committee recommended that the court should not specify a minimum period of detention (para 4.43) but rather that the sentence should be reviewed every two years with the continued need for detention being determined by the Parole Board.

The issues discussed within the Butler Report continue to have considerable resonance with recent debates. Within chapter 5 titled 'Psychopaths' the report begins by focusing on the key question of "what to do about the psychopath" (Butler 1975, para 5.1).
The tautological nature of the construct of psychopathy was recognised by the committee as having a bearing not just on the clinical process of diagnosis but also on how the law should be framed: this point was addressed by the committee in paragraph 5.27 as follows. The committee's report quotes from a submission received by them and contained within the report of a Royal Commission (1957), Cmnd.169, para 339:

> "The treatment and the use of compulsion must be based on a medical diagnosis of the individual patient's mental condition, not merely on evidence of his behaviour. The difficulty is that with patients in the psychopathic group it is their behaviour which provides the main evidence of their mental condition".

The Butler Report heard evidence (para 5.19) to the effect that psychopathic disorder should be removed from mental health legislation; among the arguments advanced in favour of removing this category were that of insufficient definitional clarity and lack of agreement among psychiatrists regarding diagnosis: the final argument advanced in favour of deleting references to psychopathy from mental health legislation reads:

> "Witnesses also drew attention to the fact that in Scotland and Northern Ireland it has not been found necessary to make use of this term in legislation" (Butler 1975) (para 5.20) (f).

also:

> "… it seems to us that it would not suffice simply to delete references to "psychopathic disorder" despite the apparently satisfactory experience in Scotland of its omission from the corresponding statute: it is one thing to have an Act of Parliament which has never included the term, but another to withdraw it after it has been in a statute for 16 years" (Butler 1975, para 5.24).

This pragmatic response does not appear to be based on a positive view of the diagnostic legitimacy or usefulness of the inclusion of the so-called psychopathic group; rather it seems to be based on a concern that removal of this group would have the potential to bring the law into disrepute. The political problem of removing categories already established within legislation also specifically informed the thinking of the Millan Committee with reference to the explicit inclusion of personality disorder. This will be discussed subsequently within this thesis.

The description of the operational similarity between the legislation in Scotland and England / Wales described within the report of the Butler Committee is of particular significance, not least because it foreshadowed the decision that would later be made in respect of Reid (Reid v Secretary of State for Scotland (1998) UKHL 43). This ruling will be discussed further subsequently. The effect of this ruling by the House of Lords was that the legislation within both jurisdictions i.e. the Mental Health Act 1983 and Mental Health (Scotland) Act 1984, in respect of psychopathy and the so-called psychopathic group, should be interpreted as having the same intention and consequently that it should be equivalent in its effect. The Butler Committee discussed the possibility of using the broader term personality disorder as a substitute for psychopathic disorder, however the committee concluded that:

> "It would not be possible to provide a usable definition in the Act for "personality disorder" which, as we have indicated, is a group of disorders" (para 5.24).

The Butler Report also contains an interesting discussion regarding treatability and the proper role of medicine vis-à-vis treatment and control. The overwhelming weight of evidence received by the committee was deeply pessimistic regarding the possibility and efficacy of treatment. The committee summarised the weight of evidence that it had received by making reference to a statement from one witness that:

> "There is no known treatment for the great majority of psychopaths and control is all that medicine has to offer" (para 5.34).

This raises the important question of whether or not control alone is an ethically legitimate function of medicine. This is relevant to the inclusion of the treatability criterion within the Mental Health Act (Scotland) 1984; this was inserted in recognition of the need to differentiate between medical interventions based on the possibility of providing some benefit to the patient, or at least prevention of further deterioration rather than merely containing them. This reflected a position long established in Scots law based on the view that:

> "Psychiatric detention of the seriously mentally disordered has underlying it the compassion and intention that medical treatment will relieve the patient's morbid condition, or at least provide him with the care and nursing that the condition requires" (Hunter 1975, para 125) .

This second aspect of the treatability criteria, namely prevention of deterioration, was to prove of critical importance in the landmark cases of Reid and Ruddle to be discussed subsequently. Concern about the disruptive impact that those within the so-called psychopathic group have upon others, whether in hospital or prison, is once again raised within this report. This is consistent with the administrative imperative previously discussed:

> "In prison or hospital they are a source of anxiety to their fellow prisoners or patients, as well as to staff. If they are located with the rest of the prison or hospital population they represent an unsettling element and the risk of unexpected violence has to be accepted and lived with. If on the other hand they are located separately, they make a further demand on scarce accommodation and staff, and may present special problems of control. On any of these counts, they are not usually suitably placed in local psychiatric hospitals……. These dangerous psychopaths have therefore usually been sent to prison" (Butler 1975, para 5.37).

The next paragraph identifies the need for an experimental programme and special regime, to some extent thereby anticipating the establishment of special facilities to support the Dangerous and Severe Personality Disordered agenda advocated by the Department of Health, Home Office and HM Prison Service (2004). This document reveals that the Government, in respect of England / Wales, continued to use DSPD as a

pseudo-diagnosis despite the very widespread criticism that this has attracted, this will be discussed further in the next chapter.

The Hunter Report (1975), that considered the legal framework for crime and sentencing in Scotland was published in the same year as the Butler Report. The Hunter report contains an arguably less sophisticated definition of dangerousness than appears within the Butler report:

> "...dangerousness-defined as the probability that he will inflict serious and irremediable personal injury in the future" (Hunter 1975, para 122).

The previous experience of preventive detention is briefly discussed within this committee's report and has a strong resonance with debates concerning the more recent UK Government policy focus upon Dangerous Severe Personality Disorder. The following observation is offered with this report:

> "It has been the experience of other countries...with... preventive detention provisions that provisions of this kind catch too many people, and not necessarily the right ones" (Hunter 1975, para 128).

The report of the Hunter Committee also closely resembled the approach subsequently adopted by the MacLean Committee, in that it recognised an ethical dilemma associated with the preventive suspension of liberty:

> "Any solution to the problem of how best to protect the public from those offenders who, on all the evidence, are very likely indeed, if at liberty, to commit further serious crimes of violence, raises difficult matters of principle; a careful balance must be struck between the rights of the individual offender and the safety of the public" (Hunter 1975, para 126).

The report proposed the introduction of:

> "...a new court disposal, entitled a public protection order…. which would be available, under an extensive range of safeguards, for the detention for indeterminate periods of dangerous offenders" (para 127).

This represents a significant point of concordance between the two jurisdictions given that the Butler Report published in the same year also favoured indeterminate sentences, the main difference being that the minimum age in the Hunter Report was specified as 16 whereas in the Butler Report it was 17.

It is clear that the intention of the proposed Public Protection Order was to address a perceived shortcoming in the age limit contained within the Mental Health (Scotland) Act 1960 i.e. that so-called psychopaths over the age of 21 could not be detained within its provisions, the psychopathic group is specifically identified here thus:

> "Different provisions apply to the detention of persons who are 21 years of age than to that of older persons under the Mental Health Acts: in practice this could have the result that persons over the age of 21 who qualified for a Public Protection Order might, if under 21, be detainable under the Mental Health Acts. There is, however, some reluctance on the part of mental hospitals to agree to accept as patients young persons with psychopathic tendencies who may not be susceptible to treatment and who may create especial difficulties for the staff. In any case, not all violence-prone persons would be diagnosed as psychopathic. In view of the present inadequacy of the medical resources devoted to the younger age group and the existence of very dangerous persons in the 16-21 age group who would not, in any event, be detainable under the Mental Health Acts the Sub-group suggest that the lower age limit to be set at 16" (para 133).

The Butler Report favoured indeterminate sentences as did the Hunter Report: both reports also recommended that indeterminate sentences should not be accompanied by a specified period of determinant detention but favoured a two yearly review period. The Butler Report contains similar safeguards to that recommended in the Hunter Report namely that:

> "...the court is satisfied, on the evidence of two psychiatrists one of whom must report orally, that the offender shows or has shown evidence of mental disorder but that he cannot be satisfactorily

> dealt with under the Mental Health Act 1959, whether because his disorder is not sufficiently severe or because no suitable hospital will receive him or for other reasons, for example, that he is a psychopath with dangerous anti-social tendencies" (para 4.42).

Both the Butler and Hunter reports also share the same recommendation that release from the proposed new orders i.e. Public Protection Order and the Reviewable Sentence should be dependent upon an assessment of dangerousness.

The Impact of the Carstairs Tragedy

An historical turning point regarding practice within Scotland (Darjee and Crichton 2003), can be identified with the escape from Carstairs by Thomas McCulloch and Robert Mone. In making their escape McCulloch and Mone murdered a fellow patient and nurse, also seriously injuring a police officer. These events, which took place in 1976 and the subsequent Reid Report (1977), proved to have a profound effect upon the interpretation and application of mental health law within Scotland concerning those who attract a diagnosis of personality disorder.

The shock caused by these events resulted in a fault line between Scotland and the jurisdiction of England / Wales. An examination of the report into these tragic events reveals why these murders had such a profound impact upon those working within the State Hospital and cast a

wider shadow over those with a diagnosis of personality disorder within Scotland. The report reveals that these two patients had been able to fashion and assemble an array of weapons. As a consequence of this, the courageous endeavours of a nursing officer to prevent their escape ended in his murder. The report details how the patient McCulloch was able to produce multiple weapons until the attempts by the nursing officer to disarm him were ultimately rendered futile; the report reads like a plot from a horror film:

> "He (MacLellan) could not have known McCulloch had a number of weapons and there is a nightmare quality in the way in which McCulloch was able to produce one weapon after another and to attack MacLellan until the latter was no longer able to defend himself" (p 14).

Having escaped from the confines of the State Hospital, Mone and McCulloch disguised as nurses, stopped a motorist intending to steal his vehicle; they were prevented from doing so by the intervention of a passing police car containing two officers who were themselves attacked before their vehicle was stolen by the two escapees.

In discussing how these patients prepared for their escape, the report identifies a pattern of behaviour that fits the archetypal violent psychopath described by Cleckley (Hare 1993): namely that they were utterly ruthless and self-serving, being able to deploy the mental skills of

calculation and problem solving in formulating a complex plan supported by the unreserved willingness to use extreme violence.

Following these events and the publication of the associated report, the marginalised status of those with a diagnosis of personality disorder increased: the stigma associated with a diagnosis of personality disorder produced an increasingly exclusionary effect within Scotland in terms of responses from those charged with responsibility for providing mental health services. These exclusionary practices appear to have been justified by the treatability criteria incorporated within the Mental Health (Scotland) Act 1984 (Darjee and Crichton 2003). The treatability criteria came to be reinterpreted by psychiatrists within Scotland in such a way as to legitimise the exclusion of those with a diagnosis of personality disorder from services. The disparity in the comparative and proportionate rates of detention of patients with a principal diagnosis of personality disorder in the State Hospital for example, compared with the English Special Hospitals, proved to be a consistent feature of medico-legal practice for the remainder of the 20th century and was acknowledged by the MacLean Committee who noted that:

> "11.7 The special hospitals in England (broadly equivalent to the State Hospital in Scotland) accommodate a **much higher** proportion of patients with a primary diagnosis of personality disorder than does the State Hospital. This reflects both differences in mental health law (the Mental Health Act 1983 in England has a specific category of psychopathic disorder) and a different tradition

within the English special hospitals" (MacLean 2000) – my emphasis.

There is reason however to believe that the MacLean Committee were however not entirely correct to attribute the difference in rates of detention to the lack of a specific category within Scots law, given that during the 1960s and 1970s those with a diagnosis of personality disorder were being admitted to and treated at the State Hospital (Darjee and Crichton 2003). The more substantial reason for the difference between these two jurisdictions, in terms of the admission of those with a primary diagnosis of personality disorder to special hospitals, is therefore more accurately attributed to a change in clinical practice. The explicit treatability criterion contained within the Mental Health Act (Scotland) 1984 appears to have come at an opportune moment within the context of this change in practice in Scotland (Darjee and Crichton 2003).

Mental health legislation in the 1980s – and the continuation of the nominate and innominate distinction between English and Scottish legislation

The Mental Health (Scotland) Act 1984 continued the established pattern within Scotland of including a psychopathic group implicitly, as distinct from English / Welsh legislation that contained an explicit psychopathic group in accordance with established legislative practice within that jurisdiction.

Part 1, s.1 (2) of the 1984 Act defines mental disorder as "mental illness however caused or manifested", in total three categories were incorporated namely mental disorder, mental impairment and severe mental impairment. Strong similarities exist between the Scottish and the English / Welsh 1983 Act. Specifically the definitions of mental impairment and severe mental impairment are virtually identical.
The Mental Health Act 1983 contained a separate category concerning psychopathic disorder, defined as follows:

> "...persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" Part 1, s.1 (2).

Within the Mental Health (Scotland) Act 1984, the unspecified presence of the psychopathic group can be clearly seen within the grounds for detention, together with the treatability criterion: Part 4, s.17 (1)(a)(i):

> "...in the case where the mental disorder from which he suffers is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct, such treatment is likely to alleviate or prevent a deterioration of his condition".

The same treatability criterion for this group is included in the grounds for detention within the Mental Health Act 1983 in Part 2 s. 3 (b):

> "In the case of psychopathic disorder or mental impairment such treatment is likely to alleviate or prevent a deterioration of his condition".

The fact that the treatability criterion contained within both pieces of legislation is identical, lends weight to the argument that there was no intention by those who drafted the Scottish bill to exclude those with a diagnosis of psychopathic personality disorder from the terms of the legislation within Scotland; nor is there evidence of any intention to exclude those with a diagnosis of any other form of personality disorder. This was in fact the interpretation subsequently offered by the Mental Welfare Commission for Scotland (Dyer 1999) following the ruling in the case of Reid (1998).

A significant change in the legal position of those classified as falling within the psychopathic group can therefore be identified by comparing the 1960 and 1984 Acts. The 1960 Act specifically prohibited the admission of the unspecified psychopathic group for anyone over the age of 21. This prohibition was eliminated within the 1984 Act, with the age restriction being replaced by an enhanced treatability criterion. Within the 1984 Act the presence of the unspecified psychopathic group however continues to be clearly evident within the grounds for detention within s.17 (1)(a)(i).

Despite the greater publicity received by the case of Noel Ruddle, the key precedent in determining the meaning and scope of the treatability

criteria within the Mental Health (Scotland) Act 1984, was actually established in the case of Alexander Reid (Crichton, Darjee et al. 2001). In ruling in the case of Reid the House of Lords confirmed that the 1984 Act did not permit detention without the prospect of benefit to the patient, also stressing that the unlabelled subcategory within Scots law should be regarded as coterminous with psychopathic disorder. This had the effect of meaning that the Mental Health (Scotland) Act 1984 should be interpreted in precisely the same way as the Mental Health Act 1983, in respect of those falling within this diagnostic category. The House of Lords (1999) held that:

> "Section 17(1) of the Act of 1984 describes the grounds on which a patient may be admitted to a hospital. It says that the ground which must be applied, in the case where the mental disorder from which the patient suffers is a persistent one manifested only by abnormally aggressive or seriously irresponsible conduct, is that medical treatment in a hospital is likely to alleviate or prevent a deterioration in his conduct. This provision gives effect to the policy that psychopaths should only be detained under compulsory powers in a hospital where there is a good prospect that the treatment which they will receive there will be of benefit" (my emphasis).

Reid however was not released following this ruling, because the Court considered that he might benefit from detention within a secure setting. It was the subsequent release of Noel Ruddle that was to set off a train of events, leading the Scottish Parliament to rush through emergency

legislation to close what became characterised as a legal loophole; this will be discussed in greater detail subsequently.

Other landmark events that illustrate the pervasive influence of the discourse of risk and dangerousness include the incident that took place on New Year's Day 1993, when Ben Silcock who had been previously diagnosed with schizophrenia, managed to enter the lion's den at London zoo. His actions only caused harm to himself and there was no evidence that he had been seeking to avoid treatment; on the contrary the evidence suggests that his efforts to access treatment had been rebutted. Despite these facts, the then Secretary of State for Health pronounced the very next day, that it was imperative for the Government to push ahead with implementing what were then referred to as Community Treatment Orders, intended to ensure that unwilling and reluctant patients received the treatment they required not least for the protection of others (Jones 1993).

Subsequently in 1996 the murders of Lynn and Megan Russell by Michael Stone, served as a further catalyst and justification for efforts that had to that point been unsuccessful, to introduce legislation based on media-led concerns about the lack of treatment compliance among patients and the risk that they represented to the public (Nash 2006). These anxieties became inextricably bound up with the contentious concept of Dangerous and Severe Personality Disorder; this will be discussed in greater detail in the next chapter.

As previously indicated, 1999 proved to be a landmark year for mental health legislation within Scotland; in making his ruling regarding the application for release by Noel Ruddle, Sheriff Douglas Allan observed that the lack of benefit or alleviation from symptomatic deterioration, likely to result from his continued detention, meant that in effect his detention was no different from imprisonment, this being unlawful and in breach of a previous ruling by the European Court of Human Rights under the terms of terms of Article 5 sub-paragraph 1 (e) of the Convention. In delivering his ruling, Sheriff Douglas Allan acknowledged that whilst it was possible for the structured environment at the State Hospital to amount to treatment due to the potential benefits to some patients, in the case of Ruddle:

> "...there was no evidence of the applicant's condition being alleviated or prevented from deterioration……. In this regard, his present detention seems no different in its effect from that which would result where the applicant in prison" (paragraph 10.4)

As a consequence of this the Sheriff ruled:

> "...since the medical treatment which the applicant has received and is at present receiving has not alleviated or prevented and is not likely to alleviate or prevent a deterioration of his condition, he does not meet the "treatability test" and it is not appropriate for him to be liable to be detained in a hospital for medical treatment,

nor to remain liable to be recalled to hospital for further treatment" (paragraph 10.6).

The successful appeal against his continued detention by Noel Ruddle appears to have caught the newly formed Scottish Parliament and its Executive by surprise; this despite the fact that the previous ruling in the case of Reid, discussed above, meant that such a outcome was only a matter of time (Crichton, Darjee et al. 2001). This ruling did not so much act as a tipping point as an explosive trigger resulting in the enactment of emergency legislation in the form of the Mental Health (Public Safety and Appeals) (Scotland) Act (1999), this being the first legislative act of the new parliament. This legislation represented a sea change in favour of an explicit policy for mental health law based upon public protection, or perhaps 'politician protection', over and above considerations of treatability that had been given such importance in the drafting of previous legislation (Crichton, Darjee et al. 2001).

The Act required the continued detention of a restricted patient in hospital, if it was necessary to do so in order to protect the public from serious harm "whether for medical treatment or not". The legislation had the effect of requiring a Sheriff to refuse any appeal for discharge of a restricted patient in the event that there were serious concerns regarding public protection, whether or not the patient actually required treatment in hospital (Crichton 2001). This piece of legislation was controversial, not least because it amended the definition of mental illness to include

personality disorder, thereby conflating two categories that had historically been regarded as fundamentally different.

This legislation was represented by its advocates as closing a loophole; however this can be viewed somewhat ironically when it is considered that what became characterised as a loophole, had been incorporated quite deliberately within the previous legislation as a safeguard (Crichton, Darjee et al. 2001). This is further evidence that the discourse of dangerousness has come to represent a prism through which law, policy, practice and procedures have come to be viewed. According to the Scottish Executive it was clearly the intention of Parliament to incorporate those with a diagnosis of personality disorder within the previous legislative framework NHS MEL (1999)73, in much the same way as the corresponding English / Welsh legislation:

> "The Act makes clear that the term "mental disorder" in the 1984 Act includes personality disorder" (paragraph 2).

This interpretation was also supported by the Mental Welfare Commission for Scotland, who argued that the misconception regarding the perceived exclusion of personality disorder from mental health law in Scotland arose as a consequence of the phraseology used within the legislation:

> "The problem goes back to the original drafting of the 1984 Mental Health Act. This made it clear that those whose mental disorder consisted only of a personality disorder, though that term was not

used in the Act, could only be detained in hospital if they were considered 'treatable' " (Dyer 1999) paragraph 2.

It is interesting to note that whereas the various reports that have been discussed previously referred to psychopathic personality disorder, the term used by the Scottish Executive and the commission is that of the broader term personality disorder.

These statements go some way to explaining why the position adopted by the Dunlop Committee (1958) in rejecting the recommendations of the Percy Commission (1957), vis-à-vis the explicit inclusion of the category of personality disorder within mental health law, in favour of an unstated and implicit recognition ultimately proved to be unsustainable. This was not because the logic of the position was necessarily flawed but because of the political imperatives characteristic of the risk society (Beck 1992).

Conclusion

The legal status of the diagnosis of personality disorder, and more specifically psychopathy, has proved to be historically contentious. The diagnosis of personality disorder has brought into focus and on occasion conflict, a number of powerful discourses and professional interests; most notably concerning medical and legal constructions of knowledge and territorial boundary disputes. Degenerationist-eugenic anxieties regarding population deterioration, and the perceived threat to the established

social order from an increase in the numbers of those perceived to be ungovernable, have proved to be historically significant factors in the development of mental health policy and legislation. The administrative imperative to maintain order and discipline within institutional settings gave rise to particular concerns about those within the so-called psychopathic group.

Those who have attracted a diagnosis of psychopathy have been regarded to varying degrees as unknowable and perhaps unspeakable, while at the same time being regarded as a distinctly recognisable group perceived as representing a particular kind of threat, in turn requiring particular kinds of legal and administrative responses. These responses have been substantially based upon the imperatives of good administration and management within prison and hospital settings. These imperatives contributed to policies based upon intensive supervision, segregation and exclusion.

A tension between the jurisdictions of Scotland and England / Wales is evident regarding whether or not this particular group should be explicitly acknowledged within statute law. This tension has given rise to a complex interaction between the two jurisdictions, resulting in an apparent pattern of divergence and convergence in mental health legislation. This pattern emerged within the context of a general preference towards concordance in statute law by lawmakers throughout the United Kingdom. The apparent historical differences in legislation between the neighbouring jurisdictions of Scotland and England / Wales, based on the nominate v

innominate inclusion of those with a diagnosis of personality disorder have ultimately proved to be largely illusory.

The principal difference between these two jurisdictions arises within the domain of practice; most notably in terms of the Scottish State Hospital and the English Special Hospitals. These differences emerged in the mid-1970s in substantial part as a reaction within Scotland to the murders that took place at the State Hospital at that time. The marginalisation of those with a diagnosis of personality disorder from service provision increased due to the interpretation by clinicians of the provisions contained within the Mental Health (Scotland) Act 1984. This resulted in significant differences in the proportion of those admitted to the respective State Hospital and Special Hospitals with a principal diagnosis of personality disorder. The position adopted by clinicians within the State Hospital from the mid-1970s onwards, is likely to have influenced practice more widely with Scotland due to demographic differences namely population size and the consequent smaller number of key personnel within Scotland, as compared to England / Wales. The position adopted more recently concerning personality disorder by key personnel at the State Hospital supports this conclusion will be discussed in the following chapter. As discussed within the previous chapter, personality disorder has to different degrees operated as a diagnosis of exclusion within both jurisdictions and more widely. Practice in Scotland has been influenced by particular historical events. The difference, at least as concerns the impact upon those who received a diagnosis of personality disorder during this period, should therefore be understood as a matter of degree within a

policy, practice and legal context characterised by segregation, isolation and exclusion (National Institute for Mental Health in England 2003).

The landmark case of Noel Ruddle and the discussion surrounding the emergency legislation passed by the Scottish Parliament in 1999 heralded a change in policy and language, such that the term personality disorder became routinely used instead of the much narrower term psychopathy, or psychopathic personality disorder. This represents an apparently much broader and more inclusive approach towards those who attract a diagnosis of personality disorder; albeit fundamentally driven by the administrative imperative and concerns about risk discussed above: this is exemplified by the decision to amend the definition of mental illness contained within the Mental Health (Scotland) Act 1984 based upon the reframing of a safeguard as a dangerous loophole. The extent that this apparently more inclusive approach has been realised will be discussed further in the findings chapters to follow.

Chapter 4:

The Mental Health (Care and Treatment) (Scotland) Act 2003 and the Reform of Mental Health Law in Scotland

Key debates and issues

Introduction

This chapter will offer an analysis of the key debates and issues underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003. This will involve contextualising changes in legislation, within the UK and Scotland more specifically against a background of broader developments across a range of other jurisdictions. The process of reform in Scotland will be contrasted with that of England and Wales in order to emphasise important differences between the two jurisdictions. The work of the MacLean and Millan Committees will be specifically considered in order to examine the basis upon which mental health law in Scotland currently stands.

Competing Discourses and the Origins of Current Law and Policy in Scotland

Between 2005 and the publication of its report in 2008 the Union Européenne des Médecins Spécialistes (UEMS) found that out of 42

European states whose policies were examined, that 57% had adopted new mental health legislation: within a significant number of these jurisdictions a clear shift towards community-based care in policy and law was evident (Strachan 2009).

In order to understand the current context in which practitioners work it is necessary to move beyond the historical analysis presented in the previous chapter, and consider more recent key developments within the policy and legal framework. The development of law and policy concerning personality disorder has been substantially influenced by three factors namely: the growth of a rights-based approach to mental health legislation, the influence of what may broadly be termed a service user movement and a neoliberal preoccupation with risk and governance (Ferguson, Barclay et al. 2003).

Rights-based claims to services have their origins within service user advocacy movements and are also deeply embedded within international legal frameworks. In the case of the former, organisations such as the Scottish Association for Mental Health (Scottish Association for Mental Health 2009) established in 1923 and MIND stemming from The National Institute for Mental Health, established in 1946, have continued to emphasise the importance of the focus upon the rights and entitlements of service users (MIND 2011). The right and entitlement to appropriate mental health care is however also incorporated into a range of international protocols and agreements including those under the auspices of the World Health Organisation (1986; 2003; 2005).

The need to comply with human rights obligations (The British Institute of Human Rights 2006) has been particularly significant in debates concerning the reform of mental health legislation (Home Affairs Committee 2000) throughout the United Kingdom including Scotland. The Human Rights Act 2000 incorporated the European Convention on Human Rights into UK law. Within Scots law more specifically the Scotland Act (1998) explicitly incorporated the European Convention of human rights into Scots law as part of the devolution settlement. Debate concerning the nature and limits of the reform of mental health legislation has tended to coalesce around the following three human rights:

- the right not to be tortured or treated in an inhuman (World Health Organisation 2003) or degrading way;
- the right to respect for private and family life, home and correspondence; and
- the right to liberty.

The process of reform in Scotland took a significantly different path from that of England, such that concerns regarding the potential infringement of human rights became far less contentious (Patrick 2006). The reform agenda of the UK Government was (Home Office and Dept of Health 1999) and remains substantially driven by a preoccupation with risk and dangerousness (Webb 2006), reflecting a broader shift within policy in many of Western jurisdictions (McCallum 2001). Developments in Scotland do not reflect quite the same emphasis; nevertheless the regulatory framework that has been implemented does reflect the same

neoliberal preoccupation with governance and regulation, this will be explored within the findings chapters of this thesis. To understand the current legal context of the provision of mental health services in Scotland, it is necessary to explore the pivotal roles played by the MacLean and Millan Committees.

The MacLean Committee

The MacLean Committee (MacLean 2000) published its report concerning 'Serious Violent and Sexual Offenders' in 2000. The work of this committee proved to be decisive (Darjee and Crichton 2002) in steering the process of legislative reform for Scotland in a somewhat different direction to that favoured by the UK Government, which was consistent with the expansion of the carceral archipelago (Foucault 1991) that has become characteristic of public policy more generally (Rodger 2008). Reflecting however the favoured policy framework of the UK Government, predicated upon linking dangerous and severe personality disorder (DSPD) (Chiswick 1999; Farnham and James 2001), this committee was required within its terms of reference to give specific consideration to the relationship between personality disorder, risk and dangerousness. In effect the committee was invited to accept the rationale underpinning the Green Paper 'Managing Dangerous People with Severe Personality Disorder' (Home Office and Dept of Health 1999), predicated upon the assertion that risk and by extension dangerousness could be directly inferred from the diagnosis of certain disorders, specifically certain forms

of personality disorder. This Green Paper was published in July 1999 and the report of the expert committee established to review these proposals, the Richardson Committee, was published in November 1999. The Richardson Committee emphasised the need for appropriate tests such as that of capacity, before compulsory measures could be taken in respect of someone with a diagnosis of a mental disorder. This expert committee recommended the inclusion of personality disorder within any new legislation, arguing that the use of the phrase psychopathic personality disorder should be discontinued. This committee acknowledged that the inclusion of a capacity test would probably mean that many people who are given a diagnosis of personality disorder would be exempted from compulsory treatment. The UK Government emphatically rejected the proposals of this expert committee, not least because of the emphasis placed upon a capacity test and treatability criterion: the UK Government regarded these specific proposals to be fundamentally inconsistent with its policy objectives as laid out in the Green Paper (Home Office and Dept of Health 1999) referred to above. Giving evidence to the Health Select Committee the Home Office Minister Paul Boateng emphasised that:

> "I think it is only fair to share with the Committee at the outset that the Government's proposals on dangerous people with severe personality disorder are first and foremost a criminal justice measure and they should not be confused with the issue of mental health and these very important reforms" (Boateng 2000).

The minister clarified that mental health legislation needed to be changed, in part to ensure that psychiatrists were required to participate in the treatment of those with a diagnosis of personality disorder. The treatability criterion contained in the Mental Health Act 1983 was regarded by the Government as a major obstacle to this. In his response to the committee the minister also restated the Government's commitment to preventative detention.

The MacLean Committee considered and rejected the rationale of linking diagnosis with risk and dangerousness thereby providing:

> "...an alternative perspective on the problem of offenders with personality disorder to that of the Home Office and Department of Health for England and Wales" (Darjee and Crichton 2002:6).

The committee rejected the attempt to introduce a form of preventive detention by further 'medicalising risk' stating that:

> "... we are not convinced that a medical protocol is the best mechanism for dealing with services for, and treatment of, offenders with personality disorders" (MacLean 2000:S 2.32)

The committee instead favoured the continuation of the established position in Scotland, whereby those with a primary diagnosis of personality disorder, are not generally admitted to the State Hospital or other psychiatric institutions. To achieve this aim the committee

recommended the introduction of an Order of Lifelong Restriction to allow for the supervision and where necessary constraint of the freedom of an individual throughout the entirety of their life:

> "In those high-risk offenders where the mental disorder is solely one of personality disorder we anticipate that the sentence will normally be an OLR rather than a psychiatric disposal" (MacLean 2000:S 7.4)

The UK Government conceded at an early stage, that its proposals for preventive detention were not evidence based, claiming however that the situation was too dire to wait for an evidence-base to be developed (Home Office and Dept of Health 1999). The MacLean Committee rejected this rationale, highlighting the specific lack of an evidence-base as a reason for not proceeding along this particular legislative pathway. Referring to their terms of reference the committee noted:

> "The remit therefore carries the implication that the presence of a personality disorder is a potentially important component in those who commit serious violent or sexual offences. We do not think this implication should be over-stated. Our approach to the problem of serious violent and sexual offenders has consistently been governed by the identification and management of the risk they present to society rather than by the presence or absence of any particular psychological or medical condition" (MacLean 2000: S 10.2).

The recommendations of the MacLean Committee were of particular significance not least because the Millan Committee that had been established to review the Mental Health (Scotland) Act 1984, was required as part of its remit to take cognisance of any recommendations made by the MacLean Committee in respect of offenders with a diagnosis of personality disorder. Freed from the conceptual muddle of the preventive detention / DSPD policy framework, the Millan Committee were able to make recommendations that would be out of step with the reform agenda of the then UK Government. The consequence was that the process of reform in Scotland was significantly less contentious (Darjee and Crichton 2004), thereby enabling new legislation to be drafted and enacted significantly more quickly than in England and Wales (Barber, Brown et al. 2009).

The Millan Committee

The Millan Committee was established in December 1998 by the Minister for Health at the Scottish Office. The committee presented its final recommendations in a report published in January 2001 (Millan 2001). The Scottish Executive accepted the recommendations (Brankin 2004) of both the Millan and MacLean Committees. These recommendations were incorporated within the programme for Government published in January 2001 (The Scottish Executive 2001). In October 2001 the Scottish Executive published a more detailed policy statement (Department of

Health and Community Care 2001), providing the basis for the draft Bill and the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Millan Committee adopted a consensual approach to the development of its recommendations: after an initial consultation exercise the committee issued a second consultation exercise inviting comment on its detailed recommendations. This process meant that the committee's final recommendations "reflected a broad consensus among key stakeholders" (Brankin 2004).

The work of the Millan Committee represented the first substantive review of mental health legislation in Scotland since introduction of the Mental Health (Scotland) Act 1960. The committee adopted a principle based approach from the outset, arguing that any new legislation "should be based on principles stated on the face of the Act itself" (Millan 2001:xv). The committee further stated that the need for a fundamental review of mental health legislation in Scotland arose substantially due to the emphasis under the Mental Health (Scotland) Act 1984 upon hospital based treatment. The committee noted that in the period between 31st of March 1986 and the same period in March 2000 that the number of general psychiatric inpatient beds within Scotland had reduced from 12,191 to 3,835 reflecting a general shift to a more community orientated approach to meeting the needs of service users. The committee were therefore of the view that legislation and practice had become out of alignment in this crucial respect.

The committee acknowledged the differences between the Mental Health Act 1983 and the Mental Health (Scotland) Act 1984 in terms of personality disorder and more specifically psychopathic personality disorder. The committee noted that section 17 of the Scottish legislation did include psychopathic disorder by implication; whereas it was explicitly incorporated within the English legislation. The committee noted that the position in Scots law had been amended by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, such that personality disorder was explicitly brought within the definition of mental illness. Despite acknowledging some advantages of reverting to the position prior to 1999, the committee acknowledged that:

> "...it would not be realistic to ignore the fact that the 1999 Act has given new emphasis to the question of personality disorder":44.

The committee acknowledged that explicitly including personality disorder within mental health law in Scotland was not entirely consistent with practice among Scottish psychiatrists. In an oblique reference to the UK Government's proposals in respect of Dangerous and Severe Personality Disorder, the committee noted that:

> "... the problem cases in future are not, in practice, likely to be those with a sole diagnosis of anti-social personality disorder..." (Millan 2001:44) .

On-going differences of opinion among psychiatrists, concerning those with a diagnosis of antisocial / psychopathic personality disorder in different jurisdictions, were also noted in the literature review conducted as part of the work of the Millan Committee. The views of the Irish Division of the Royal College of Psychiatrists for example were highlighted, these being based upon a position opposite that of English law such that:

> "...most of those with a psychopathic personality disorder should be excluded (from admission to hospital settings)" (Atkinson and Patterson 2001:24).

With specific reference to whether or not compulsory measures should be available for those with a diagnosis of personality disorder the committee observed that:

> "Few, if any, Scottish psychiatrists are likely to recommend compulsory measures in such cases" (Millan 2001:44).

The committee however took the pragmatic view that personality disorder should not be excluded from the realm of compulsory treatment, as the effect of excluding the use of compulsory measures in respect of personality disorder, would be likely to result in excessive legal debate concerning whether or not any given individual should fall within the legal category of having a mental illness or personality disorder. The committee therefore favoured the inclusion of personality disorder within the sphere

of compulsory measures, believing that the rights of patients would be adequately protected by the specific tests also recommended by the committee concerning impaired judgement, risk and benefit from treatment.

These tests were intended to replace the treatability test that had been included in the Mental Health (Scotland) Act 1984 and Mental Health Act 1983 to safeguard against the detention of those with a diagnosis of personality disorder who were not likely to benefit from treatment and to preclude preventive detention. As discussed in the previous chapter the treatability test was at the centre of legal debate in the cases of Reid and Ruddle - prompting the political crisis that led to the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. The committee took the view that the application of a treatability test to one group of patients only i.e. those with a diagnosis of personality disorder, could no longer be justified on the grounds that it was too arbitrary: instead they recommended a broader range of tests that should be applied in respect of mental illness, learning disabilities and personality disorder. This is consistent with the position advocated by the World Health Organisation that mental health legislation should not be predicated on concerns regarding dangerousness but rather that of:

> "...promoting the rights of persons with mental disorders as people and citizens" (World Health Organisation 2005:1).

In direct contradiction to the UK Government's preference for preventive detention and in keeping with the guidelines provided by the World Health Organisation, the committee emphasised that although the so-called treatability test was no longer fit for purpose, that:

> "...the underlying aim of the test, to avoid the Act being a vehicle for preventive detention, is an important one":63.

The committee acknowledged the debate concerning the nature and status of personality disorder and took this into account in reaching a view about whether to recommend its explicit inclusion in mental health legislation. The committee noted that while personality disorder did not feature significantly in Scotland, in terms of detention and the use of compulsory measures, that it did represent an important element of health care, most notably regarding the obligations of local authorities and the Mental Welfare Commission. The working assumption was therefore that those who attract a diagnosis of personality disorder would be likely to receive services primarily on a voluntary basis as informal patients.

In keeping with the Millan Committee the Mental Welfare Commission also supported the inclusion of personality disorder as part of a tripartite definition of mental disorder (Health Committee 2002), in the context of a principle- based approach intended to provide adequate safeguards against the improper use of mental health legislation.

The principles (Lyons 2008) embodied in the Mental Health (Care and Treatment) (Scotland) Act 2003 are –

any person discharging functions under the 2003 Act shall have regard to:

- the past and present wishes and feelings of the patient
- the views of relevant others (named person, carer, guardian or welfare attorney)
- the participation of the patient
- information and support for the patient
- the range of options available
- the provision of maximum benefit
- non-discrimination
- respect for diversity
- minimum restriction of freedom
- the needs of carers
- information for carers
- the provision of appropriate services

The principles as presented within the report of the Millan Committee (Millan 2001) are subdivided into four categories namely Justice, Autonomy, Beneficence and Non-malfeasance. This explicitly follows the so-called four principles approach (Beauchamp and Childress 2009) that has become increasingly influential in the sphere of bioethics.
There is general agreement (Patrick 2006) that the principles contained within the Act substantially reflect the Millan Principles. The decision by the Millan Committee to explicitly include the four principles of autonomy,

justice, beneficence and non-malfeasance was endorsed by the Union Européenne des Médecins Spécialistes (2008) in its report concerning the future of legislation in Europe in respect of compulsory treatment for those diagnosed with a mental disorder (Strachan 2009).
The Millan Committee recommended that the concept of mental disorder, subdivided into the three categories of mental illness, learning disability and personality disorder should provide the overarching framework of a new mental health Act for Scotland.

As part of the literature review underpinning this thesis, a request was made and granted, for access to be given to the responses to the second consultation exercise. An analysis of these responses was conducted focusing upon: 1) the specific principles recommended for inclusion within a new Act; 2) the proposed definition of mental disorder; 3) the specific inclusion of personality disorder within the definition of mental disorder: the analysis of these responses will now be discussed.

Responses to the Second Consultation Exercise

This analysis has particular relevance to the first research question that focuses upon the ways in which the inclusion of personality disorder in Scots law might reflect an acknowledgement of the legitimate needs and rights of service users.

Overall the responses to this consultation exercise were welcoming of the recommendations of the Millan Committee; this suggests that there was fairly widespread acknowledgement of the legitimate needs and rights of those who may attract a diagnosis of personality disorder to appropriate services. There were however some concerns expressed regarding the practicality of including the principle of reciprocity. The Association of Directors of Social Work and the British Medical Association in particular raised concerns about this specific issue. These concerns were also echoed by the Royal College of Physicians Edinburgh. Perhaps surprisingly the Royal College of Psychiatrists offered no comment in respect of the specific principles, although they did offer favourable comments to the Health Committee considering the subsequent draft Bill (Health Committee 2002). The Greater Glasgow Health Board strongly welcomed the inclusion of reciprocity, whereas The Greater Glasgow Primary Care NHS Trust made no substantial comment.

Organisations representing and advocating on behalf of service users generally expressed strong support for the inclusion of the principles including reciprocity. The National Schizophrenia Fellowship however expressed some concern that the principle of reciprocity could be perversely used to deny service users access to services, on the grounds that the services available were not of a sufficiently high standard. In contrast to the position adopted by the Association of Directors of Social Work, Renfrewshire Council very strongly supported the inclusion of the principle of reciprocity. The Law Society of Scotland endorsed the principles and specifically welcomed the inclusion of reciprocity.

The use of the umbrella term 'mental disorder' was not endorsed as widely as the specific principles. Notably the Law Society of Scotland argued that the term mental disorder should not feature within any new legislation but rather that a functional approach should be adopted. The Law Society of Scotland argued in favour of a broad approach to a definition that would not have the effect of excluding people who might potentially benefit from the provisions of the Act. The British Association of Social Workers favoured an emphasis on capacity rather than the use of specific categories. The Association of Directors of Social Work broadly welcomed the term mental disorder but expressed specific reservations concerning the explicit inclusion of learning disability and personality disorder as categories of mental disorder.

A number of organisations representing and advocating on behalf of service users strongly objected to the use of the term mental disorder; this included ENABLE Scotland who also objected to the inclusion of learning disabilities as a specific category. People First argued that learning disability should not be included but rather that separate legislation should be enacted to provide for this group of service users. The Scottish Association for Mental Health strongly objected to the inclusion of the term mental disorder, arguing that it was not capable of proper definition, arguing instead in keeping with the Law Society for Scotland that the concept of capacity should provide the basis for a definition. Once again, somewhat surprisingly, the Royal College of Psychiatrists offered no specific comment regarding how mental disorder should be defined and whether or not this term should be used at all; this

is perhaps suggestive of the recognition that the law may not be the most effective means of achieving real change and that attitudes, values and practices are perhaps ultimately more important (Pilgrim, 2012).

With regard to the specific inclusion of personality disorder as a named subcategory of mental disorder, a broad range of views was expressed by respondents. The Association of Directors of Social Work observed that the diagnosis of personality disorder was inherently problematic, expressing concern that this diagnosis was open to abuse. This respondent also noted however that it was a matter of fact that those with personality disorder represented a very significant proportion of mental health service users. Glasgow City Council argued that if personality disorder were to be included, that an explicit treatability test should be retained in keeping with the Mental Health (Scotland) 1984. The Greater Glasgow Health Board broadly welcomed the proposals but cautioned that health care agencies should not become embroiled in social control. The Greater Glasgow Primary Care NHS Trust emphasised that those who experience difficulties associated with a diagnosis of personality disorder should be free to seek assistance on a voluntary basis, noting also that they should be liable to detention if necessary. This response is interesting, not least because it underscores the very significant difference between being granted permission to seek services, as distinct from having a right to services! Renfrewshire Council expressed the view that on balance personality disorder should be specifically included; concerns were however noted regarding the potential for a diagnosis of personality disorder to be used as an

illegitimate means of social control. Organisations representing and advocating on behalf of service users, expressed favourable views concerning the inclusion of personality disorder. The response of the Consultation and Advocacy Promotion Service for example, welcomed the specific inclusion of personality disorder, based on the assumption that this would increase the rights of service users to receive an appropriate service.

The contention that the Millan Committee succeeded in adopting a consensual process appears to be well supported by the responses to the consultation exercise. The Millan Committee specifically highlighted the change in practice within Scotland as elsewhere within the United Kingdom, following the NHS and Community Care Act 1990: this heralded a move away from institutional to community-based care towards care delivered in the community. As indicated previously this change in emphasis and practice was identified by the Millan Committee as a significant factor in the need for new mental health legislation. The importance of this trend had been noted previously by the Scottish Affairs Committee in two separate reports (1995; 1997).

In response to the 1995 report by the Scottish Affairs Committee, the Scottish Office made an undertaking to develop a strategy document concerning the delivery of local mental health services; this resulted in the publication of A Framework for Mental Health Services in Scotland (Scottish Office and Dept of Health 1997). This important framework notably omitted any reference to personality disorder, instead focusing on

the more traditional concern for those with severe and enduring mental health problems by specifically referring to:

> "...the service needs of people with severe and/or enduring mental health problems, including those with dementia" (Scottish Office and Dept of Health 1997:para 6).

Ruddle's Law

As noted previously the ruling in respect of Noel Ruddle in August 1999, triggered the emergency legislation widely referred to as Ruddle's law, namely the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 enacted in September of that same year. In the period between the publication of the MacLean Report in June 2000 and the Millan Report in 2001, the Scottish Executive stated its commitment to accelerate the implementation of the framework for mental health (Scottish Executive Health Dept 2000). This commitment was further restated in the programme for Government published by the Scottish Executive (2001). Later that same year the Scottish Executive published Renewing Mental Health Law (Dept of Health and Community Care 2001) in keeping with the commitment to implement reforms based on the Millan Report made in the programme for Government. This included a commitment to retain the probability of benefit as one of the criteria to be satisfied in respect of compulsory measures, in marked contrast to the legislation eventually enacted in England and Wales (Barber, Brown et al. 2009) in which the

notion of probability is replaced by the notion of mere intention (Mental Health Act 2007). Changes to mental health law in Scotland were underpinned by a national programme for improving mental health and well-being (Scottish Executive Health Dept 2003) that ran between 2001 and 2006: this sought to increase the profile of mental health issues, challenge stigma and reduce the incidence of suicide. The draft mental health Bill was published in 2002 and subsequently received Royal assent as the Mental Health (Care and Treatment) (Scotland) Act 2003.

In contrast to subsequent developments in England and Wales (M.H.A. 2007), the Scottish legislation retains a number of key features incorporated within the Mental Health (Scotland) Act 1984. This includes the probability of benefit in respect of the use of compulsory treatment and also the retention of specific exclusionary criteria. In keeping with the draft Bill for England and Wales (Dept of Health. 2002), these exclusionary criteria were however omitted from the draft Bill (Scottish Executive. 2002) for Scotland: this was in direct contrast to the stated intention to include them in Renewing Mental Health Law (Scottish Exective. 2001). These fundamentally important criteria were only reinserted as a result of lobbying from organisations such as the Mental Welfare Commission (Health Committee 2002). The Scottish draft Bill did however retain the principle of benefit, whereas this was omitted from the draft bill for England and Wales.

These exclusionary criteria are intended to prevent behaviours that may result in social, legal and moral sanction being inappropriately defined as

constituting a mental disorder. The specific exclusionary criteria are those of: sexual orientation, sexual deviancy, transsexualism, transvestism, dependency on, or use of, alcohol or drugs, behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person and acting as no prudent person would act (Guthrie 2011). This contrasts with subsequent developments in England and Wales, where the Mental Health Act 2007 that replaced the Mental Health Act 1983 despite widespread objections, contains only one exclusionary criteria namely: dependence on alcohol or drugs (Barber, Brown et al. 2009).

The debate concerning the merits of including personality disorder within mental health legislation is on-going (World Health Organisation 2005). Where personality disorder is incorporated within mental health legislation there is a particular need to ensure: "substantial legal provisions to prevent misuse" (World Health Organisation 2005):21. With specific reference to the inclusion of personality disorder in mental health legislation, the World Health Organisation cautions that this diagnosis has historically been used to control the behaviour of vulnerable groups: notably women who are deemed to be breaking social, cultural and religious mores, political dissidents and minority groups.

The first research question concerns the ways in which the inclusion of personality disorder within mental health law in Scotland reflects an acknowledgement of the legitimate needs and rights of service users. This theme is explored most notably within chapter 3, this chapter contains an analysis of how this group of service users has been viewed historically,

thereby providing a backcloth for the analysis of contemporary policy and practice discussed in chapter 4 of this thesis. Chapters 3 and 4 provide an important part of the contextual analysis described in more detail within chapter 5 where methodological issues are discussed more fully. The second research question concerns personality disorder within the broader context of neoliberal strategies of regulation and control. This question is explored more fully in chapter 8; however chapter 3 contains the historical ground work necessary to understand the contemporary context of regulation and control: key concepts include the administrative imperative and emphasis upon those who fall within this diagnostic category being viewed as a problem population to be managed. The third research question concerns how the inclusion of personality disorder is perceived and responded to by front-line workers. Much of the ground work for the contextual analysis of the emergent empirical findings that address this question are set forth in the second chapter that examines personality disorder as a diagnosis cloaked in misunderstandings and embedded moral interpretations of conduct. The fourth question concerns the relationship between current legislation and the availability of services. The background to this is covered within chapter 4, where the key debates and policy issues that provide the backcloth against which the emerging findings can be understood and analysed are mapped out. The fifth research question concerns the ways in which current legislation has influenced the ability of those who attract a diagnosis of personality disorder to actually access appropriate services. Chapters 2, 3 and 4 all play a role in providing a contextual framework that can help to explain the emergent empirical findings in respect of this particular question. The

process of providing a contextual framework through which to understand and interpret the emergent findings presented in the later chapters of this thesis, was based upon the meticulous historical and comparative analysis that is presented in chapters 2, 3 and 4. This study exemplifies the process of theorising and contextualising data described by Layder, most clearly within his critique of grounded theory (Layder, 1982). This theoretical framework is explained more fully within chapter 5 where methods are specifically addressed.

Conclusion

The process of reform that paved the way for the Mental Health (Care and Treatment) (Scotland) Act 2003; can be understood as part of a broader shift in many jurisdictions from care and treatment for those diagnosed with a mental disorder being provided within institutional settings, towards a greater focus on care and treatment being provided in the community. In parallel with this there has been increasing emphasis upon the rights of service users as citizens (World Health Organisation 2005).

The process of reform in Scotland should be understood in the context of the broader reform agenda of the UK Government; this is evidenced by the similarities in the draft Scottish Bill with that of proposals for England / Wales in respect of the exclusionary criteria. As noted above these exclusionary criteria for the use of compulsion were only reinstated as a

consequence of lobbying during the passage of the Bill through the Scottish Parliament.

The extent that the explicit inclusion of personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003 can be understood as a positive preference, as distinct from reflecting a range of political imperatives will be further explored within the findings chapters of this thesis. Emergency legislation in the form of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 was a response to the successful appeal against detention by Noel Ruddle. The enactment of this emergency legislation was consistent with the emphasis being given to personality and dangerousness by the UK Government. In other respects however developments in Scotland have diverged significantly from those in England and Wales. The MacLean Committee was instrumental in rejecting the attempt by the UK Government (Home Office and Department Of Health 1999) to conflate personality disorder, risk and dangerousness. The retention of the key test of benefit with a criterion of likelihood rather than mere intention, together with the retention of more specific exclusionary criteria, represent major points of departure between the two legislative jurisdictions.

The Mental Health (Care and Treatment) (Scotland) Act 2003, is consistent with international protocols and the principles of good practice advocated by the World Health Organisation (2003). The 2003 Act is predicated upon several fundamental assumptions including: that mental health legislation should be broad-based and inclusive; that a strong

emphasis should be maintained on the need for clear safeguards in respect of the use of compulsion and that services should be delivered in a manner that meets the needs of service users rather than institutional priorities. This legislation represents a point of departure from the position that has developed in England and Wales where there is less emphasis in the legislation concerning safeguards, thereby reflecting the policy agenda of the UK Government predicated on preventive detention (Home Office and Department Of Health 1999), albeit in a more limited form. The Mental Health (Care and Treatment) (Scotland) Act 2003 has rightly become widely regarded as: "an example of progressive, humane legislation" (Ward and Patrick 2007).

The inclusion of the diagnosis of personality disorder within this legislation potentially opens a gateway for those who attract this diagnosis to seek access to services. The assumption contained within the report of the Millan Committee that those who attract this diagnosis would be likely to receive services on an informal / voluntary basis, however means that the obligation upon statutory services to become accessible to this potential group of service users remains less clearly defined. This might be considered somewhat paradoxical in that inclusion without compulsion may mean that access to services is far harder to achieve; whereas inclusion based on compulsion has been rejected for this group of service users on the basis that it would very largely be inappropriate and potentially oppressive. The extent that the presumption in favour of informal / voluntary treatment has impacted upon access to and the

provision of services will be discussed within the findings chapters that follow.

Chapter 5:

Methodology and Theoretical Considerations

Introduction

The purpose of this chapter is to provide an account of the theoretical considerations and value commitments that have underpinned and driven this research forward, together with the methods by which the research has been designed, implemented and analysis conducted. Before providing details of the design, implementation and analysis of my empirical research, consideration will first be given to two specific areas. The first concerns the value commitments of the researcher and an acknowledgement of how they have influenced the entire process from the literature review through to the empirical research and analysis of findings. The second concerns the importance of the insights provided by Layder (1982; 1989) regarding the relationship between social theory and the conduct of empirical research: the implications of these insights will be discussed in terms of their influence upon the design, conduct and analysis of the empirical research that is central to this thesis.

The broad value position underpinning this research is consistent with a critical approach to psychiatry, rather than one of anti-psychiatry. The basic assumption underpinning critical psychiatry (Newness, Holmes et al. 1999; Thomas and Bracken 2004) is a scepticism concerning the predominant reliance upon biological medicine to provide an explanatory

framework for the relationship between mental phenomena and behaviour; the emphasis instead being placed upon causal explanations rooted in the social, economic, cultural and political spheres (Critical Psychiatry Network 2010).

Personality disorder - definitions and application within this research

The diagnostic category personality disorder represents an example of how processes of classification can result in potentially divergent approaches to understanding the same phenomena. In accordance with the DSM and ICD personality disorder has come to be understood as:

> "...long-standing and maladaptive patterns of perceiving and responding to other people and to stressful circumstances (National Institute for Clinical Excellence 2007).

The DSM and ICD:

> "Both require an individual to have an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of their culture, is pervasive and inflexible across a range of situations, leads to significant distress or impairment, is stable and of long duration (with onset in childhood, adolescence or early adulthood), and cannot be explained as a manifestation or

> consequence of other mental disorders, substance use, or organic brain disease, injury or dysfunction" (National Institute for Clinical Excellence 2007).

As highlighted within the earlier literature review the concept of personality disorder is inherently tautological. As part of a broader discursive formation constituted by the psy-disciplines (Rose 1999a), the identification of specific patterns of perception and conduct are used to deduce the existence of a disorder of the personality; the disorder of the personality in turn is then used to:

> "...personify the particular forms of knowledge which the discourse produces" (Hall 2001:80).

This self-referential process has particular implications when a diagnosis becomes inherently stigmatising: the diagnosis of personality disorder being a case in point (Ferguson, Barclay et al. 2003). This has been discussed within the previous literature review in terms of a spoiled identity (Goffman 1963). An alternative approach to understanding these patterns of behaviour that is finding increasing acceptance is that of trauma: from this perspective personality disorder can be thought of as akin to post-traumatic stress disorder (Castillo 2003). Such an interpretation is consistent with the increasing emphasis on social perspectives in mental health (Tew 2004). The notion of trauma may invoke a very different and potentially less stigmatising response to that of having a disordered and therefore 'faulty' personality. Significantly a

trauma-based approach explicitly acknowledges the aetiology of personality disorder in exogenous factors i.e. external trauma, thereby potentially reducing the tendency to perceive the problem as endogenous, implying that the individual is in some sense 'faulty'. Whatever the subjective reality experienced by those who may attract a diagnosis of personality disorder, or indeed any other diagnostic label, the process of classification is necessarily socially constructed. As indicated in the quotation above from NICE, the diagnosis of personality disorder is based upon cultural norms: this is necessarily so because the implicit concept at work here is that of social functioning, this having a strongly normative dimension and based on cultural and historical contingencies. This is illustrated very well by the historical analysis of the development of manners and changing expectations of behaviour within social situations (Elias 1978).

In keeping with the above, this research has not sought to establish whether or not personality disorder 'exists' in any objective sense; rather the starting point is the acceptance of the subjective distress and suffering typically experienced by those who may attract such a diagnosis. Equally this research has not sought to elicit the views of respondents concerning how personality disorder should be understood ontologically; rather the focus is upon how the respondents have sought to engage with those who may attract such a diagnosis. This research incorporates an analysis of policy that follows from the views expressed by the research participants and the analysis of published policy and strategy documents.

Theoretical Considerations and Value Commitments

The focus of this research concerns those who may attract a diagnosis of personality disorder following the decision to include personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003. The purpose of this research has been to explore the nature and extent of the inclusion of those who may attract a diagnosis of personality disorder within current mental health law in Scotland. The process of enquiry has been driven by three primary areas of concern namely: the extent of inclusion, alternative explanations for inclusion and the potential consequences of inclusion for those who may attract this diagnosis. The research questions have been framed and reflexively reframed during the course of this enquiry in order to focus as clearly as possible upon this triad of concerns.

The process of enquiry and observation can never be one that is value free, even if that were considered desirable (Morris 2006): it is of particular importance therefore that the researcher is self-aware and openly acknowledges the value position that underpins the process of inquiry.

The current emphasis upon evidence-based practice can result in the objectification of the lives of service users, at the expense of a richer and deeper understanding of their lived experience. Such an approach can result in social work practitioners and researchers putting on "a metaphorical white coat" (Butler 2003:22) and paying inadequate

attention to the details of the context in which thoughts, behaviours and actions are situated. The alternative more politically engaged approach acknowledges that social work practice and research is a moral endeavour that is ultimately not conducted to generate objective truths; rather its purpose is to provide greater understanding of the relationship between seemingly individual actions and choices, within the broader social and political context in which they are embedded (Butler 2002). This approach to constructing knowledge is intended to be fundamentally emancipatory in its orientation. From this perspective social work practice and research should be:

> "...partisan, critical, counter-hegemenic and value driven" (Butler 2003:22).

This research is based upon a decision by the researcher to reject the politically neutral and amoral approach to research engendered by the current focus upon evidence-based practice (Butler 2003). This research is underpinned instead by a fundamental belief that the end goal of research should be primarily emancipatory (Beresford 2001), and that researchers should seek to promote the interests and well-being of service users at all times. This means that the research should seek to shine a light upon structures and processes that potentially disadvantage service users in making legitimate claims upon services. This approach builds upon Husband's notion of the morally active practitioner (Husband 1995) by extending this to the field of social work research (McLauchlin

2009). This approach draws upon an existentialist tradition (Hugman 2003) such that taking:

> "...a moral stance means to take responsibility for the Other; to act on the assumption that the well-being of the Other is a precious thing calling for my effort to preserve and enhance it, that whatever I do or do not do affects it... it does not depend on what the Other is, or does" (Bauman 1994:19).

The subjective experience attested to by many service users of marginalisation and exclusion, has been supported by numerous investigations (Ferguson, Barclay et al. 2003; Castillo 2003) that have provided confirmation of the objective reality of this lived experience: this reality formed part of the fundamental rationale for the development of the research proposal underpinning this thesis.

The analytical method employed in undertaking this research falls within the interpretivist paradigm. The importance of acknowledging the social nature of human behaviour and decision-making has long been acknowledged within the social sciences, one of the most notable examples being Weber's employment of the concept of verstehen (Weber 1968; Hughes 1993). Crucially from an interpretivist perspective there can be no process of observation and therefore research that is independent of theory, rather researchers whether they choose to believe so or not, are necessarily active participants in constructing narratives to describe and explain phenomena. This principle holds equally for

phenomena that are more obviously social typically concerning attitudes and behaviours, or seemingly based upon scientific laws e.g. Newtonian physics. This is because the knowledge base that any explanation may be derived from is necessarily imbued with ideas and themes that are to some extent socially and historically contingent (Hughes 1993). On the one hand this means that positivist assumptions of objectivity are illusory but also that the atheoretical approach advocated within certain versions of grounded theory is also equally unattainable (Layder 1982). The essential point that Layder seeks to make is that the analysis of emergent findings must take account of a range of evidence from other sources, so that the analysis is informed by an understanding of the broader social and political context. The contextualisation of the process of analysis is required if a balanced and coherent analysis of explanatory value is to be produced. The dynamic relationship between values, knowledge and power is captured well by Foucault's notion of 'regimes of truth' (Foucault 1980); for Foucault truth much as the individual is an effect of power:

> "...produced only by virtue of multiple forms of constraint" (Foucault 1980:131).

This process of constraint is derived from the struggle to position certain forms of knowledge as valid, and for individuals by virtue of their status e.g. doctor or lawyer to be designated as legitimate bearers of this knowledge.

This research is specifically informed by Derek Layder's adaptive theory (Layder 1982; Layder 1989). While accepting the principal criticisms of positivism offered by proponents of grounded theory, Layder argues that a purely inductive method as advocated within strong versions of grounded theory, whereby meanings are said to effectively reveal themselves, is both unattainable and inherently undesirable. The alternative model proposed by Layder is based upon the explicit recognition of the necessity of prior theorisation to provide a context in which research can be planned, conducted and to some extent analysed. Crucially however the attitude of the researcher must be one in which prior theorisations do not have an overly privileged status; rather they should serve as a vehicle for helping to explore empirical data rather than corralling it within predefined categories. This means that the research process should be reflexive and based upon an iterative process of constant comparison (Glaser and Strauss 1967), allowing themes to emerge from the data rather than being constrained as described above. Layder (1982) argues that this inductive process of constant comparison:

> "...does not automatically vitiate the use of rationalistic... forms of theorizing":103.

Layder instead argues that the process of constant comparison is positively aided by being contextualised within an acknowledged theoretical framework. Layder does not therefore seek to define himself in opposition to empiricism; rather he asserts that his position can best be described as post-empiricist. This approach embraces practices such as

purposive or theoretical sampling, in which potential research participants are identified by a process that involves some degree of prior theorisation.

In keeping with grounded theoretical approaches, the adaptive model proposed by Layder also emphasises that the research design must to some extent be on-going and itself emerge as part of the process of inquiry and exploration. As an alternative to 'groundedness', Layder proposes the idea of 'substantive embeddedness' (Layder 1982), in an attempt to overcome what he regards as a false opposition between induction and logico-deductive methods:

> "...embeddedness involves the possibility of using first-hand field research methods in conjunction with rational and discursive modes of theoretical knowledge":112.

The rationale behind this attempt to bridge the gap between these approaches that are often positioned oppositionally is that it allows for the acknowledgement of the objective conditions that fundamentally shape the context in which the process of empirical fieldwork takes place e.g. power relations based on variables such as class, gender, race and so forth, while at the same time allowing meanings to emerge out of the data in a way that gives genuine expression to the views and perceptions of those who are the focus of the research.

The aspiration behind this approach is that knowledge and theory are produced as a result of:

> "...the outcome of a dialectical interplay between relatively autonomous and prior, theoretical knowledge about the objective features of social life (particularly structures of power and domination), and the regulatory activities of field research" (Layder 1982:112).

Layder seeks to differentiate substantive embeddedness from groundedness, by emphasising that the researcher should not regard the commonsense perceptions of research participants as privileged in a way that means they simply have to be accepted without further analysis. The limitations of an exclusive emphasis upon the empirical identification of the views and beliefs of research participants characteristic of early versions of grounded theory, has been widely acknowledged such that it has become commonplace to move the focus of research "beyond the knowing subject" (Clarke 2009:200). Layder seeks to capture the relationship between objective conditions / structures and subjective experience through the concept of "contexts of enactment" (Layder 1982:117). In adopting this perspective Layder takes his lead from the dramaturgical approach previously explored by Goffman (1959) whereby social actors are said to relate to each other and make decisions in much the same way that actors perform roles on stage. Individual performances are the result of both objective conditions such as how the performance is staged, the individual characteristics of the actors

including differences in role perception and the response of those who are observing: most notably the audience, critics and those who the performers may regard themselves as more directly accountable to such as the director.

The crucial point that Layder is making here is that researchers may well have knowledge of contextual factors that inevitably impact upon the perception of research participants in ways that they may not always, and in some cases, almost certainly could not be aware of (Gallagher 2008). It should be noted that the contextualisation of perception applies to all research participants as well as the researcher. The perceptions and decision-making processes of professionals, such as social workers, researchers and medics, are also susceptible to forces that shape the context and environment in which they work, for example the pervasive marketing techniques of pharmaceutical companies (Smith 2005).
The approach underpinning substantive embeddedness is therefore one that emphasises the:

> "...interplay...between revelation and pre-givenness in the generation of theory" (Layder 1982:113).

One of the implications of adopting this approach is that researchers must be aware of objective structures that are likely to have a significant impact upon individual perception and the attribution of meanings, including power differentials between different groups of professionals or the significance of status hierarchies within professional groupings. This

approach therefore emphasises the interconnections between objective conditions and subjective experience. Such an approach is therefore in no way anti-empirical; rather the fundamental assertion is that the context in which the process of empirical inquiry is conducted must be acknowledged if a thorough analysis is to be undertaken.

As outlined above Layder's characterisation of human interaction follows Goffman's seminal work on how people seek to create and manage their identities while interacting with others (Goffman 1959). Goffman observed that the etymology of the word person is that of a mask and argued that our use of the word person represents:

> "...a recognition of the fact that everyone is always and everywhere, more or less consciously, playing a role...It is in these roles that we know each other; it is in these roles that we know ourselves" (Goffman 1959:30).

This analysis of social life has particular significance for those who may for a variety of reasons find it more difficult to manage the dramatic encounters that form the basis of social interactions. Goffman subsequently explored this in greater detail in his analysis of the effects of stigma upon human identity and social interactions (Goffman 1963). These ideas are used within this thesis to analyse the specific problems faced by those who may attract a diagnosis of personality disorder arising from implicit expectations of service readiness (Vale, Watts et al. 2009) a concept that will be defined and explored within chapter 6.

Research Design, implementation,analysis and recruitment of participants

In order to guard against the potential problem of the views of the researcher being superimposed upon the research process an advisory group was recruited. This advisory group consisted of representatives (N = 4) from the statutory and voluntary sectors together with one representative from another HEI. The role of the advisory group was to provide comment on the design of the research instruments and to provide additional ethical oversight. Discussions were held with the regional coordinator for the National Research Ethics Service regarding the potential need for their approval; however this was not deemed necessary as the recruitment pathway for respondents did not involve any medical practitioners or any issues of medical confidentiality.

The research instruments consisted of semi-structured interviews using an itemised schedule (see appendix 3). In addition to the above, ethical consent was sought and obtained from the larger of the two local authorities, the smaller local authority accepting the approval process of its larger neighbour. This process involved the submission for scrutiny of all of the research protocols and instruments. The research design and instruments were approved by the relevant ethics committee within the Department of Applied Social Science at the University of Stirling. Throughout the design and implementation of the research specific consideration was given to the ethical imperative of safeguarding the welfare of all potential participants. Arrangements were made to provide

appropriate support in the event that any participants became distressed as a consequence of their involvement in this research. In addition to the clear requirement for a general duty of care towards potential and actual participants in the research, more specific consideration was given to the importance of confidentiality. The need to safeguard the identity of participants was regarded as particularly important, not least due to the contentious nature of the diagnosis of personality disorder and issues relating to the provision of services for those who may attract this diagnosis. Given the contentious nature of this subject, by participating in this research all respondents were of necessity making themselves potentially vulnerable to criticism. The anonymity of participants was therefore maintained by assigning each respondent a coded number with their real identity being stored in an encrypted database. A double consent procedure was utilised, meaning that after indicating their willingness to participate in the research by means of completing a document agreeing to an initial exploratory meeting, a further consent form was signed by those participants who agreed to proceed. The purpose of this double consent process was to ensure that participation in the research was based on informed consent (Davies 2001).

The approach taken to the design of the empirical research was intended to provide an effective means for the exploration of the five questions underpinning this research namely:

1. In what ways does the inclusion of personality disorder within mental health law in Scotland reflect an acknowledgement of the legitimate needs and rights of service users?
2. How does the inclusion of personality disorder within mental health law fit into a broader range of strategies of control and regulation characteristic of an advanced liberal democracy?

3. How has the inclusion of personality disorder influenced the way that those who attract this diagnosis are perceived and responded to by front-line workers?

4. In what ways has current legislation influenced the availability of services for those who attract a diagnosis of personality disorder?

5. In what ways has current legislation influenced the ability of those who attract a diagnosis of personality disorder to access appropriate services?

Within the context provided by the literature review and analysis of policy and law, semi-structured interviews were used to explore these questions. The role of the key informants (N = 9) was to provide a broader policy and strategic overview; whereas the role of the psychiatrists and mental health officers participating in the research was that of exploring the details of actual practice. The key informants were selected by means of purposive sampling (Glaser and Strauss 1967;

Eisenhardt 2002). One example of this concerns the identification of a key informant within the Personality Disorder Network. Initial thematic analysis identified that this network was more significant than I had originally assumed and that one person stood out as being of particular significance in Scotland. Key informants occupying positions of strategic importance or having specific knowledge of policy were identified and approached. The most crucial of the key informants included representatives from the Millan and MacLean Committees, I deemed it highly desirable to try and recruit these respondents who were in a position to offer authoritative comment on the proceedings of these committees and the recommendations that were ultimately to follow. In addition to this it was necessary to obtain the views of someone at the heart of the policy process in Government. A number of psychiatrists occupying positions of particular influence within the area encompassed by the research were identified and approached, they were selected to try and ensure as far as possible that the views of practice from this group of respondents were as relevant as possible. These psychiatrists were identified from publicly available documents indicating their position within the organisations in which they were employed. Other psychiatrists were approached based on information received from key informants and MHOs together with other psychiatrists themselves. The intention was to identify those psychiatrists who were in positions of greatest influence within the area encompassed by the study. In addition to the 7 psychiatrists interviewed for this research an additional 3 were approached and from whom no response was received. The reasons for the lack of response from these three necessarily remain obscure;

however given the demands upon the time of this particular group it is perhaps unsurprising that not all chose to respond. This combination of participants allowed a thematic analysis of policy and practice to be conducted. All participants were offered a choice of venue for the interview, to ensure as far as possible that they did not feel in any way constrained and in recognition that they may not necessarily wish to be identified as participating in the research.

The breakdown of participants

Social workers/MHOs	20
Psychiatrists	7
Key informants	9 (one key informant working for an organisation championing the rights of mental health service users was also self-identified as a service user)

N = 36

Out of those who were interviewed of the MHOs 68% of respondents were female, for key informants and psychiatrists the percentages were both 50% male-female. During the course of reflecting upon the interviews, no discernible differences were identified based on the gender of respondents. Consideration was given to collecting additional

demographic information regarding respondents; however this was not done on the basis that to produce any substantive analysis using this information would require significantly larger numbers of participants than for the purpose of the qualitative analysis at the heart of this study. Participants were recruited from the Greater Glasgow area. This involved two adjacent local authority areas. An invitation to participate was distributed electronically via e-mail to all social workers who were also mental health officers (MHOs) within these two areas. E-mail addresses for MHOs in the larger authority were made available in order to permit me to directly make contact with each MHO. There were 75 names on the list of MHOs for this larger of the two local authorities. Contact with the MHOs in the smaller of the two authorities was made on my behalf by a manager within that service; there were 15 MHOs potentially available for interview within this local authority. In total therefore 90 named MHOs were invited to participate in this research. It subsequently transpired that as a consequence of the database not being entirely up-to-date and a number of named individuals no longer being in post, together with a number of MHOs being unavailable due to sickness absence, that the actual number of MHOs available to participate in the study was lower than the 90 referred to above. Based on the responses received it would have been possible to have interviewed another 15 - 20 MHOs should that have proven necessary. Attempts to recruit MHOs, psychiatrists and key informants were discontinued when theoretical saturation had clearly been achieved.

The intention had been to recruit service users via mental health officers. The mental health officers participating in the research were able to identify a number of potential service user participants: the identities of these potential participants were not disclosed to the researcher without the prior explicit consent of the service user. A number of service users agreed to allow their contact details to be passed to the researcher to allow further discussions to take place before any decision about their actual participation was reached. For a combination of reasons no service users actually became available to participate in the research via this recruitment pathway. The reasons for this were either that of loss of contact with the referring agency and mental health officer or deterioration in the health of the service user. One service user was recruited as a result of their key role within a service user advocacy organisation. It had been anticipated that recruiting service users would be quite challenging and to this end an appropriate period of time had been allowed; the reality of the recruitment process however turned out to be more problematic than originally envisaged, such that it became impossible to complete this within a reasonable timeframe. In an attempt to try and address this contact was established with a key service user-led organisation for those who have been given a diagnosis of personality disorder. Despite being a UK wide organisation however, it was found that this organisation did not have an active network in Scotland at that time and no alternative network could be identified. Consideration was given to developing an alternative recruitment pathway for service users based on information provided psychiatrists and nursing staff within community mental health teams: this however would have required an entirely

separate process of ethical approval. The practical reality of the necessary time contraints meant that this ultimately proved to be unviable. The empirical findings of this research therefore substantially reflect the views of key informants, psychiatrists and mental health officers. Given the disparity in size between the larger and smaller local authority from whom the participants in this research were drawn, the majority of responses received and represented within the analysis contained in this thesis are from those within the larger of the two authorities.

The design of the interview schedule

The interview schedule (Appendix 3) was designed in order to provide a relevant and coherent framework within which interviews with participants could be structured. Great care was taken to ensure that participants would not feel required to give prescribed responses and that no particular responses were proscribed.

To ensure that the interview schedule reflected the key themes and issues that emerged during the course of conducting the literature review, a reflective analysis was used. This process reflected a self-conscious decision to try and give a 'voice' to the respondents rather than to superimpose explanations and conclusions upon the data.

The interview schedule went through a number of iterations in the design process in an attempt to ensure that proper consideration and weighting

was given to emergent themes and concerns. Phase 1 of this process involved a mapping exercise on paper and flipcharts to identify the key concepts, debates and issues that would need to be addressed in interviews with participants: these were then incorporated in a table using Microsoft Word entitled Themes to General Issues and Questions (see appendix 1). This information was drawn from an Excel spreadsheet created at the beginning of the research that provided a historical timeline based upon the following categories:

Year	Date	Event	Memorandum/Report	Legislation	Legal ruling	Key concepts

The category of key concept was of particular significance because this provided an opportunity to identify events, memorandums/reports, legislation and legal rulings that have been historically most significant in influencing how those who may attract a diagnosis of personality disorder are understood, classified and responded to. Under this heading the emergence and development of particular concepts such as moral insanity were also noted and tracked. Phase 2 involved operationalising these general themes, issues and questions into more specific questions relevant to each of the intended participant groups before combining them into one integrated interview schedule.

The purpose of this process was to provide both a current and historical context in which to try and understand the interrelationships between

these pivotal concepts and debates. This process followed a similar pattern to that subsequently used when I adopted NVivo as a tool to support analysis of the interview transcripts. Having reflected upon the literature review and mapped out an initial overview of the themes and concepts that seemed to me to be of greatest significance, I then re-read the literature review in a self-conscious effort to try and use these themes and concepts as a prism through which to view the literature review itself. The purpose of adopting this reflexive approach was to try and gain a sense of whether there was a good fit between these themes and concepts, or whether using them as a prism created additional tensions and conflicts, suggesting that they provided an insufficient lens through which to understand the content of the literature review. When I reviewed my initial general themes, issues and questions and how they were represented in the first draft of the interview schedule, it became clear that there were a number of duplications and overlaps between items within the schedule. To address this I went through a process of organising the themes and concepts into broad areas and then smaller areas with their own internal hierarchy. After a number of iterations, as I continued to reread my literature review, I formed the view that the themes and issues that I had originally identified had become appropriately expressed within the interview schedule. Following this the interview schedule was discussed with a practising Mental Health Officer and members of the Advisory Group to ensure it was sufficiently clear, relevant and did not contain any notable omissions.

Throughout this research process I made specific and deliberate efforts to avoid premature conclusions to ensure that my understanding and perception should continue to be fluid, thereby ensuring that I remained open to new interpretations as the research progressed.

Research Implementation

Given the contentious debate that characterises the diagnosis of personality disorder, I anticipated that participants might have some level of anxiety even though they had explicitly given their consent to meet with me. The reality however turned out to be quite different from this. At the start of each interview I ensured that participants were happy to proceed using the venue they had previously chosen, this was just in case anything had changed since they had made the original decision. I then offered the respondents an opportunity to ask about myself and discuss the background to the research more generally so that they could become comfortable with me as an interviewer and have an opportunity to express any concerns or doubts that they may have. Perhaps partly because of my own background as a social worker and extensive experience of talking to people in potentially stressful situations, the interviews with respondents quickly assumed the form of a discussion.

In accordance with the principle of constant comparison (Boeije 2002), the interview schedule continued to go through several more iterations once the formal process of interviewing participants had actually

commenced: this ensured that the research process remained fluid enough to respond to lessons learned during the conduct of each interview. Following each interview I carried out a reflective analysis. It became clear early on that certain of the items were still a little repetitive and certain others had less relevance than I had anticipated. An example of an item that did not prove to be as relevant as I had anticipated concerned the issue of compulsory treatment orders. Contrary to what I had anticipated these simply did not appear to be considered relevant by those respondents that I interviewed early on in the process. This led me to return to my literature review, as a consequence of which it became clear to me that in direct contrast to proposals for England and Wales, it had never been intended that compulsory treatment orders should have any great significance for those who attract a diagnosis of personality disorder in Scotland. As the interviews progressed I discontinued asking respondents to discuss their perception of the significance of compulsory treatment orders, unless this emerged as of particular relevance during the discussion, which in fact it did not.

As the interviews progressed it became evident that processes of bifurcation and filtration were operating that had not been fully flagged up during the course of my review of the literature. The significance of these processes will be discussed extensively within my findings chapters. In response to this emergent theme, I gave greater attention to trying to understand how the processes of bifurcation and filtration were operating and what implications these might have for service users.

The process of analysis - acknowledging emerging findings

In keeping with the emphasis upon reflexivity and process of constant comparison, I decided to adopt NVivo in order to facilitate the process of analysis. I determined from the outset that the use of the software should be as a tool and that I would not allow myself to become preoccupied with the software itself and its many fascinating capabilities, lest I become distracted from focusing upon the information that I was trying to understand. I decided therefore to make use of the software to the extent that it was helpful, rather than being determined to make use of every possible function and facility available within it.

Following each interview I continued the process of making notes and reflecting upon the extent that anything new or additional had emerged, or to what extent the information provided by participants reinforced the previous information that I had already begun to analyse. I was therefore able to use a ranking system to categorise each interview in terms of whether it offered new information or confirmed existing information. I used this ranking system in order to determine which interviews to have transcribed. Once transcribed, I made each interview a case and created a linked memo that I could update as the research progressed. These memos contained observations and comments indicating specific issues that should be followed up and cross referenced with comments made by other respondents, specific pieces of policy and so forth. These memos and the notes that I kept in my reflective log, proved invaluable in developing the nodal structure that would form the basis of my

developing analysis and subsequent findings. This nodal structure underwent a number of revisions as it became evident for example, that certain nodes were in effect providing a duplicate function and that other nodes were to be of less relevance. I ceased to conduct further enquiries once I concluded that the point of theoretical saturation had been reached (Holton 2010). I defined this as the point when the information received from respondents became substantially repetitive rather than yielding new insights.

The interview transcripts were coded deductively against specific nodes derived directly from the items within the interview schedule, at the same time new nodes were identified by coding inductively upwards from the data. A linked memo was established to each node to allow for observations, thoughts, reflections and questions to be recorded.
At regular intervals I printed out a nodal report and the precise content of each node was reviewed at regular intervals and cross referenced with the linked memos associated with each interview transcript. I asked myself the following questions: what function is this node actually serving, could this function be better served by using a different node, could this node be reasonably merged with any other nodes and finally is it necessary for this node to be subdivided into more distinct and discreet nodes? During this process a number of nodes were identified as 'overlapping' to such an extent that one could be subsumed within the other: an example of this were the nodes 'Diagnosis of Exclusion and Difficult to Manage and Problem Patients'. When I reviewed the text that had been coded in respect of these nodes it became clear that all of the comments that

related to the later node had also been coded under the former. The node Diagnosis of Exclusion also contained additional coded text and therefore became the node into which Difficult to Manage and Problem Patients was subsumed. Certain other nodes became redundant because very little or any data was coded against them e.g. the initial node relating to compulsory treatment orders.

Once the nodal structure had become stable all of the text coded at each node was copied and pasted into its own discreet word document. This allowed further consideration to be given to whether or not the text and the coding were sufficiently aligned or whether further nodes were required. This process also afforded me an opportunity to identify those comments from respondents that most clearly illustrated the meaning of the node for use in my findings chapters.

I produced a summary of the most important comments within each node before producing an analytical summary of each node that would later form the material from which the findings chapters were ultimately to be written. An example of a selection of early analytical summaries can be found in appendix 4. In keeping with the position advocated by Layder (1982), the fieldwork aspect of the research process did not therefore proceed on the presumption of tabula rasa; rather it reflected the thematic theoretical analysis of the literature review that was in turn informed by the views of the participants.

The responses of research participants have been analysed thematically, utilising an iterative inductive / deductive process. The approach used was consistent with the model described by Silverman (2005). The deductive aspect of the process of analysis stems from the fact that the responses of participants were necessarily shaped by the thematic framework underpinning the semi-structured interview schedule. The unstructured aspect of the interview process was however intended to ensure that the underlying thematic structure did not constrain the responses of participants.

To ensure that the process of analysis was robust and systematic a number of selected transcripts deemed to have the richest content were imported into Nvivo. Once these transcripts had been imported into Nvivo their existing coding was reviewed and additional nodes created by 'coding up' from the data (Richards 2002). The interviews that had not been imported into Nvivo were then listened to again to ensure that no substantive material had been omitted from analysis. This process was itself iterative because as themes emerged, previously coded transcripts were re-read to take account of the emergent properties of the findings. An example of this concerned a number of processes of filtration that emerged as particularly significant because of their effect of excluding those who may attract a diagnosis of personality disorder from service provision. These processes of filtration will be explored in detail within the findings chapters. A nodal structure was consequently developed that reflected the themes that emerged from this process of reflexive analysis.

During the coding process care was taken to avoid "destroying the meaning of the data through intensive coding" (Eisenhardt 2002:8). The process of analysis and empirical inquiry was interactive in that analysis was undertaken as the fieldwork was in progress. The rationale for this was to ensure that the themes, issues and specific questions explored with participants could be modified in order to follow-up emerging themes and issues. This process also involved reflecting on the broader theoretical position underpinning the research in recognition that:

> "...good data analysis is never just a matter of using the right methods or techniques but always is based on theorizing about using a consistent model of social reality" (Silverman 2005:186).

As indicated previously a notable example of how the process of theorising and analysis operated concerned the emergence of processes of bifurcation: it became clear that these operated on several levels, most notably based upon risk and whether or not interventions were on a voluntary or statutory basis. Once the significance of these processes had emerged, this issue was incorporated in subsequent interviews with respondents. The significance of this point is explored within the subsequent findings section.

Once I had a nodal structure that I felt confident provided an accurate reflection of the themes and issues that had emerged during the course of the research, I began the process of identifying how this could be used to provide the underlying structure for my findings chapters. The decision to

organise my findings according to the nodal structure reflected within the emergent themes and issues was in keeping with the fundamental approach adopted throughout this research; namely that of ensuring that an emphasis was given to emergence and that the voices of the participants would remain prominent. Based on the decision that I had previously made to use NVivo as a tool to the extent that it was useful, on this occasion I decided that the next step would be best conducted in a manner that allowed me to quite literally see the big picture. This is not to suggest that Nvivo would not be perfectly capable and appropriate for this purpose; however for myself at least I was aware that it was not the optimum tool for this purpose. Using flipcharts I began the process of listing my nodes and comments from memos that had been linked to them. Having completed this initial big picture overview, I then went back and reviewed the interview transcripts, to ensure that as far as possible, my nodal structure reflected the themes and concepts that had emerged. I then began to cluster my nodes into broad areas, resulting in four main clusters: Cluster 01: Attitudes and Boundaries; Cluster 02: Policy and Strategy; Cluster 03: Resource Implications; Cluster 04: Service Readiness. After further reflection upon the content of cluster 01 and cluster 04 due to their conceptual similarity these two clusters were combined to form the first findings chapter. The second and third findings chapters are respectively derived from clusters 03 and 02.

Conclusion

The methodology underpinning this research is rooted in a commitment to emancipatory values and practice with a primary ethical concern for the welfare of participants. The analytical framework underpinning this thesis reflects the theoretical insights offered by Derek Layder in his critique of grounded theory and provided the rationale for the design of the research instruments and process of analysis leading to my findings. The items contained within the interview schedule arose directly from the themes and issues identified as of particular significance within the literature review. The process of analysis was conducted in such a way as to ensure that it was systematic, integrating emergent findings with social theoretic considerations and was informed by an analysis of law / policy. The methodological approach that underpins this thesis is intended to facilitate the integration of social theoretic perspectives, with the authentic voices of the participants based on the themes that emerged through the process of enquiry and analysis.

Chapter 6:

Service Readiness and Exclusion - the role of Attitudes, Expectations and Boundaries

Introduction

The emergent themes and key findings that will be discussed within this chapter focus upon my third research question namely:

'How has the inclusion of personality disorder influenced the way that those who attract this diagnosis are perceived and responded to by front-line workers'?

This chapter of the thesis will focus upon three key findings, namely the importance of service readiness, the significance of tension between specialisation and genericism and problems arising from the interfaces between services.

In order to facilitate an interpretation of these emergent trends the attitudes and expectations of several key informants involved with the development and implementation of policy will also be discussed. Certain of the issues raised here will be followed up in greater detail within chapter 8 in the subsequent discussion of the development of policy.

The first emergent theme concerns the practical effect of particular attitudes and expectations among service providers in maintaining previous patterns of exclusion. Within this chapter the 'lack of fit' between many of those seeking services and the provision of services will be identified and explored as a key problem for those who may attract a diagnosis of personality disorder. The concept of service readiness will be used to explore processes that operate within organisations that can lead to those who attract a diagnosis of personality disorder continuing to be marginalised and excluded.

The issue of boundaries emerged as a significant theme based upon the definitions of concepts such as treatment, as well as the scope and flexibility of professional roles and responsibilities. Other important emergent themes concern the tension between specialisation and genericism that became evident during the course of this research, together with broader issues concerning how services are structured and organised. These themes will be explored by considering the tensions generated by certain developments intended to promote the greater integration of health and social work services. Following on from the analysis of changes to mental health legislation in the earlier literature review, the notion of symbolic legislation and the move away from a primarily sovereign coercive or commanding function of law, to a primarily regulatory function (Dean 1999) within advanced liberal democracies will also be noted.

Lifting the Veil - Service Readiness and Reluctant Engagement

During the course of this research the importance of service readiness became increasingly apparent. The meaning of this term is somewhat counterintuitive and will therefore be defined before proceeding with the findings and discussion. The concept of service readiness was developed in a report published by Vale and colleagues that provided a particular analysis of the relationship between need and service provision (Vale, Watts et al. 2009). Service readiness is a concept that focuses upon the expectations, both stated and unstated, that service providers frequently have of those seeking services that act as a barrier to accessing services. Service readiness describes the attributes that service providers typically expect service users to possess as a prerequisite for accessing the services that they provide (see appendix 2).

The importance of those who wish to actually become service users, demonstrating that they are able to behave in the required manner was echoed widely by respondents, most notably MHOs; the following comment sums this up this most clearly:

> "If somebody with a personality disorder walked into the… Area Team (office) and came up to the window and was acting a bit kind of strangely… They might actually be shown the door; or they might actually have the police called on them!" (R: 06 Mental Health Officer).

The expectations of service readiness are particularly pernicious because they operates largely at an invisible level, often greatly complicating the process of service users being able to successfully gain access to services. The concept of service readiness is of particular analytical value, because it helps to explain problems that have been frequently identified between the apparent lack of fit between services and those who require them: this in turn can help us to understand why unmet needs tend to become clustered among individuals and groups who are perceived as insufficiently service ready (Vale, Watts et al. 2009). Those who are most likely to be given a diagnosis of personality disorder are also more likely to find it particularly difficult to manage their interactions with others in order to increase their prospects of pressing home their claims to services. This is not least because a core feature of routine human interaction involves individuals trying to present themselves as acceptable persons, who are abiding by social conventions, in order to elicit favourable responses (Miller 1995). It is inherent in any diagnosis of personality disorder that the service user will have become characterised as having difficulties of social functioning that mean they will tend to conform less with these expectations:

> "…it can be difficult to work with the person because there is a strong likelihood they won't engage with you…in working with PD it's difficult to be able to get beyond…a sense that you're not quite engaging with somebody" (R 01: Mental Health Officer).

When considering whether to try and engage with someone with a diagnosis of personality disorder, an additional invisible hurdle was repeatedly identified by respondents based on the perceived likelihood that the service user would engage in the expected manner resulting in a question being frequently posed:

> "…if we were to get involved is the person able to undertake the tasks that they would be asked in relation to the treatment and that sometimes can be difficult because of the personality disorder" (R: 27 Mental Health Officer).

These apparent difficulties of engagement can be helpfully reconceptualised by the application of the concept of service readiness. The degree to which this process of reconceptualisation is however effective, depends substantially on a proper understanding of the concept itself. Providing that this concept is properly understood however then it offers a progressive alternative to the concept of' hard to reach' groups, a concept that tends to locate the reason for any real or apparent failure in engagement between service providers and service users with service users themselves (Stalker 2005; Brackertz 2007). This often involves service users becoming characterised as being unwilling to engage with services and therefore not yet ready to make use of the services that may be available. The notion of service readiness however locates the obstacles and impediments to potential service users successfully accessing services largely within the structure, modality and attitudes of those responsible for service provision. Those service users who do not

possess the required characteristics will tend to be classified by service providers as not being sufficiently service ready; consequently they are therefore likely to find it much harder or simply impossible to successfully access the services that they may require because they are in some sense perceived as fundamentally deceitful:

> "...my own experience of people (*who have been given a diagnosis of personality disorder)* is...that they have a mask and it's quite difficult to get behind so you're never absolutely sure, who the person is because you're getting this kind of presentation" (R 01: Mental Health Officer).

The notion of those who attract a diagnosis of personality disorder wearing a mask referred to by respondent (R:01), echoes Cleckley's assertion that those with so-called psychopathic personality disorder, masquerade as sane and reasonable by wearing a "mask of sanity" (Cleckley 1941). When applied more generally to those who may attract a diagnosis of personality disorder, this pejorative characterisation creates the potential for the stigmatisation of this group of service users as inherently untrustworthy and dishonest:

> "...nobody else would touch them (*mental health service users*) because they're difficult to engage with, violent, aggressive, whatever, and (*consequently statutory services are reluctant to engage with them and are*) just not really willing or wanting

anything to do with it" (R 16: Key Informant within a Voluntary Sector Provider).

One response to this perceived lack of service readiness is that of the subcontracting-out by agencies within the statutory sector of this area of work to agencies within the voluntary sector. This process of subcontracting-out services and tasks was particularly evident for those service users who have the most complex needs, including those who attract a diagnosis of personality disorder and are regarded as hard to reach or are insufficiently service ready. One of the most significant difficulties for service users stemming from the notion of service readiness, is that so many of the expectations held by service providers are typically unstated and may run counter to the publicly expressed aims, objectives and mission of those providing services, particularly where the stated emphasis is placed upon inclusion (Vale, Watts et al. 2009). The additional hurdles involved in trying to navigate through a potential minefield of unstated assumptions and expectations, creates the potential for added confusion and frustration among those who may attract a diagnosis of personality disorder and other groups who may be regarded as particularly at risk of marginalisation.

As discussed previously, those who are more likely to attract a diagnosis of personality disorder, which is itself based upon the perceived failure to abide by social norms and conventions, are by definition likely to find it more difficult to conform to the expectations created by the operation of professional bureaucracies, including for example keeping appointments.

Rather than adopting a more flexible approach to contact however, during the course of this research it emerged that the response in the event of a 'failure to attend' is all too often one of simply sending a letter to the service user effectively ending contact on the basis that:

> "...you've not turned (*up*)" (R 01: Mental Health Officer).

Bureaucratic responses such as this may serve to reinforce any sense of alienation and frustration that the service user may already be experiencing, and consequently may make their subsequent engagement with services more problematic.

> "...they (*statutory agencies*) don't really want to get involved (*and argue that*) that's your job because that's how we commissioned the service"(R 16: Key Informant voluntary sector provider).

The attitude of the statutory sector towards its voluntary sector partners would therefore appear to be somewhat like that of a dominant partner towards their junior counterpart in a marriage of convenience.

> "...people with borderline get the worst of both worlds. Nobody else is really helping them but they... still get admitted really quite frequently but once they're in, they're kind of resented and not given the support that they need" (R 03: Psychiatrist).

> "...whether they're (*clinicians*) too busy or whether they don't feel they've got skills or they haven't got experience or appropriate things to offer, you know, I think that's maybe why they don't dedicate more time or (*are*) more inclusive with regards to adding them to their caseloads" (R 03: Psychiatrist).

> "(Workers)...fall off the side cause they don't believe that there's something can be done so there's maybe one or two people end up still trying to keep things going. It becomes quite impossible because you've not got the commitment of other colleagues" (R 01: Mental Health Officer).

As can be seen from the above comments, it emerged during the course of this research that the continued reluctance of some clinicians to engage with those who may attract a diagnosis of personality disorder has the potential to result in unintended consequences; notably a form of double-bind resulting from the continued admission of those who have been given this diagnosis, without them being fully accepted as legitimate recipients of assistance and care. The risk here is that service users who attract a diagnosis of personality disorder come to occupy a kind of no man's land characterised by ambivalence and uncertainty concerning their status. Several possible different explanations emerged for the apparent reluctance of some psychiatrists to engage with this group of service users including: time constraints, concerns about whether they are sufficiently skilled, lack of appropriate experience and uncertainty concerning the availability of effective interventions. The common

perception of the very limited benefits of efforts to assist this group appear to increase the rate at which professionals withdraw or disengage from interventions, so that workers somewhat ironically, become hard to reach or at least it becomes difficult to maintain their engagement.

> "...they're (*Workers employed within mental health crisis services*)...all absolutely terrified and they make direct referrals to us saying, can you become involved" (R 10: Mental Health Officer).

Referrals continue to be made to Community Mental Health Teams even from those working within specialist crisis services. This would appear to be due to anxiety experienced by workers within these specialist teams about working with those who may attract a diagnosis of a personality disorder. This results in referrals to CMHTs that are not based on any clearly identified role for the CMHT; rather the referral appears to be a mechanism whereby workers seek to manage their own anxieties.

> "...why can't you (*those who attract a diagnosis of personality disorder*) just help yourself... why can't you just kind of do stuff for yourself?" (R 10: Mental Health Officer).

This respondent acknowledged that in discussions with colleagues that frustration regarding the perceived unwillingness of some service users who attract a diagnosis of personality disorder to help themselves was often used to call into question the legitimacy of their claim upon services.

Mind the Gaps - Specialisation and Integration

A tension emerged during the course of this research between the potential benefits of specialisation within the context of a more integrated approach to service provision and the practical realities experienced by workers themselves.

> "... (*social workers are being*) more and more segregated into specialist teams (*creating the*) potential for gaps and those folk that are most likely to fall into those gaps, are people with PD" (R 01: Mental Health Officer).

> "...we're (*social workers*) integrating into the medical model ostensibly" (R 10: Mental Health Officer).

The above comments from respondents (R 01 and R 10) suggest that social workers risk being marginalised in the on-going process of integrating health and social care services. The process of integrating 'into' medical approaches, if unchallenged, may curtail the scope for social workers to effectively intervene on behalf of those who attract a diagnosis of personality disorder.

Another respondent offered a slightly different view, being more positive about the opportunities that integration creates for social workers noting that:

"I think it is easier for social work, we've been reinventing ourselves now for… 10 years and I've done other things. There are nurses that get to my age and at 50 they've been doing (*the same things for*) 30 or 40 years… that's a different game" (R: 11 Mental Health Officer).

"I am not persuaded by specialist teams because I don't think that people that work in specialist teams are specialists because they come and go...from various teams but they give out an impression that they're very specialist and it's only us that can do that" (R 01: Mental Health Officer).

"...for the MHO it's become even more incredibly specialist now we're losing interfaces with other specialist colleagues" (R 10: Mental Health Officer).

> "…specialisation is quite a polarising situation in my experience working across specialisms from my previous job (*is*) no no!" (R: 07 Mental Health Officer).

"...the specialist approach is profoundly unhelpful because in a multi-agency kind of approach if your people are involved in that you want coordination and cohesion, and if you have people attending specialist services dotted here and there you really lose continuity" (R 17: Psychiatrist).

> "...you don't know that they're always getting it (*the promised package of care*)" (R 01: Mental Health Officer).

One response to the perceived problems of poor fit between the expectations and requirements of agencies i.e. requirements for service readiness, is that of establishing dedicated services and promoting specialisation among workers. Specialisation is regarded by its advocates as offering a number of key benefits to service users and potentially service providers: these typically include enabling service users to gain prompt access to those who are best placed to assist them on the basis of their knowledge and experience. The potential benefit for service providers following from the prompt matching of service users with the correct specialism should include increased overall efficiency. The potential efficiency gain follows from timely problem identification and onward referral where appropriate, together with the potential benefits from earlier rather than belated intervention. Those however who take a more sceptical view of specialisation tend to emphasise the fact that specialisation itself typically involves narrowing referral criteria, thereby making it harder for service users to actually access services. From this perspective then, specialisation whether by design or default can all too easily act as a barrier to services. The risk therefore is that one of the unintended consequences of specialisation is that it may tend to reinforce existing patterns of exclusion. This carries particular dangers for groups that have historically tended to have more difficulty accessing services, which certainly includes those service users who have attracted a diagnosis of personality disorder.

The general move within service provision towards greater service integration is potentially very significant for service users who attract a diagnosis of personality disorder, not least because this process of integration was typically characterised by respondents as largely one-directional, raising concerns that this development can be seen in terms of the broader expansion of the hegemony of the medical paradigm that tends to give priority to service users with a diagnosis of severe and enduring mental illness: this will be discussed further below.

The shift towards greater integration appeared to be accelerating during the period in which this research was conducted, as evidenced by the attempt by Glasgow City Council and NHS Greater Glasgow and Clyde Health Board, to fully merge health and social work services within Community and Health Care Partnerships (CHCP's). This project represented a very significant extension of the Community Health Partnership model. The fully integrated CHCP was subsequently abandoned in May 2010 (Samuel 2010); this followed from concerns about the open-ended nature of the financial liability that the local authority may incur and the reluctance of the health board to continue with the joint arrangement on the basis of a modified funding agreement. Despite these difficulties the current policy being pursued by the Scottish Government is based on substantially increasing the integration between health and social care services. This is expressed most clearly in the Adult Health and Social Care Integration Bill currently working its way through the Parliamentary process.

During the course of this research, as can be seen from the preceding comments from respondents (01; 10; and 17), a degree of scepticism became evident regarding one of the fundamental assumptions underpinning specialised teams; namely that they provide a means for service users to gain more ready access to relevant expert knowledge and experience. The reality of this may be called into question, not least because of the consequences of on-going processes of reorganisation, redeployment and organisational 'churn'. In addition to actual expertise and knowledge, another critical requirement for the effective operation of specialist teams is that they can appropriately refer service users onto other specialist services; this requires the effective management of multiple interfaces, both within and between different departments and agencies. Effective work across and between services is however notoriously difficult to sustain. Specialisation was therefore seen by some respondents to represent a threat to the disruption of vital interdisciplinary connections. The potential for the loss of continuity of care also emerged as one possible consequence of increasing specialisation.

Concern about the potential for service users to be "siphoned off" (R 17), particularly to the private sector also emerged as an issue within the research. In particular concern was expressed that the promises made by private sector providers, regarding the quality of their services and the skill set of their staff, could not be taken at face value due to uncertainty concerning what would actually be delivered as distinct from promised.

This raises fundamental issues regarding not just best value but accountability in the broader sense.

> "...they've (*the UK government*) spent a huge amount of money and there's all sorts of disasters going on down there (*England*) that, you know, are just bubbling to the top" (R 19: Key Informant and Psychiatrist).

This comment by respondent (R: 19), a Key informant and member of the MacLean Committee, is consistent with the concerns about the conceptual basis for the DSPD programme articulated so clearly within the report of this committee.

Specialisation - personality disorder and severe and enduring mental illness

Any debate concerning the potential merits or shortcomings of increasing specialisation needs to be contextualised within a broader acknowledgement of the way that services have and continue to be configured and the implications that this has on how services are provided:

> "Personality disorder is invariably a second comorbidity diagnosis and the primary diagnosis whether it be bipolar or whatever it is…is concentrated upon" (R: 26 Mental Health Officer).

"PDs get used as a sort of 'oh we're too busy seeing people with schizophrenia and we can't help you' sort of thing... So I think the only real way is a dedicated sort of service" (R 03: Psychiatrist).

"...they (*those with a primary diagnosis of personality disorder, even when they may have a dual diagnosis involving a mental illness*)...will not be deemed to meet the criteria of severe and enduring mental illness... more than likely they can't access those teams because they would have to be deemed as having mental illness" (R 01: Mental Health Officer).

"...they (*those with a primary diagnosis of personality disorder*)... end up not quite fitting, so the real concern is that very vulnerable people don't get through the doors of (*the*) specialist team (R 01: Mental Health Officer).

"(*That personality disorder has been*) a diagnosis of exclusion, is absolutely very apparent I think. It still is. I think even though it's included in the Act… I think it's because it doesn't fit into the medical model" (R: 05 Mental Health Officer).

The following comment was offered by an MHO who had been in practice for a considerable period of time and had practised under both the two Acts that preceded the current legislation. This comment summarises the view expressed by the majority of mental health officers:

> "What I saw was that personality disorder was used by psychiatrists as a get out of jail card… If someone was, for want of a better word, a bit of a nuisance then there was a very quick reaching for the personality disorder as being the main frame of reference for which we should approach this individual (*providing a rationale for service disengagement)* I don't detect any significant difference" (R: 30 Mental Health Officer).

From the above comments it is clear that there are fairly convincing arguments both for and against greater specialisation. One of the strongest arguments in favour of specialisation is based on the assumption that the traditional priorities following from the medical paradigm, are such that those who attract a diagnosis of personality disorder are likely to continue to lose out in the competition for resources, in favour of those groups of service users that are more firmly established within its traditional areas of interest. The implication of this finding is that the operational framework for community mental health teams has not changed adequately to reflect the explicit inclusion of personality disorders within mental health legislation. A possible consequence of this lack of fit between those who attract a diagnosis of personality disorder and the way that services are currently configured, is that those who attract this diagnosis are particularly at risk of on-going marginalisation and exclusion.

> "...people (*workers*) are sort of stuck in their ways. So I think new services are probably the most realistic way of doing it but

> obviously it's the most expensive way of going about it. But new dedicated services is the only real way to get anything done properly in the short-term. I suppose if you look at the longer term, cultural change and that sort of thing takes, you know, forever" (R 03: Psychiatrist).

The arguments in favour of specialisation centre around the need to ensure that those who attract a diagnosis of personality disorder cannot so easily continue to be overlooked in favour of those whose problems are considered to fit more comfortably with the traditional expectations of 'diagnose and treat'. The above comment from informant (R: 03) indicates that one possible response to the difficulties associated with established custom and practice would be to develop new and specifically dedicated services. It is perhaps reasonable to assume that the practical realities of such an undertaking are all the more formidable in the current economic climate. The alternative to having dedicated services is reliance upon cultural change; this however offers no guarantee of a short or even a long-term solution to the problem of service users not being able to access appropriate services in a timely manner.

The absence of specialised services for those with personality disorders means that it is quite likely that they are going to continue to be perceived as:

> "...piggybacking" (*onto services designed for those with*) "affective disorders... or schizophrenic disorders" (R 03: Psychiatrist).

The following comment succinctly represents the view typically expressed by respondents concerning the focus of community mental health teams:

> "This is a team that deals with severe and enduring mental illness" (R: 11: MHO)

Unintended Consequences and Professional Uncertainty

> "...this is the downside of The Mental Health Act, it's like, the people that have (*been detained*) on formal legislation probably do get everything coordinated well because you have to, it's just like the kids on the Child Protection Register, the people (who) are tiddling along, you know, possibly get a bit side lined" (R 10: Mental Health Officer and Practice Team Leader).

> "...with newer referrals, I think they're (*clinicians*) much more tuned in to what kind of treatment they're going to give from the outset" (R 10 Mental Health Officer and Practice Team Leader).

> "(*For those on a statutory order people will say*) Oh it's a priority piece of work...That's the difference with the new mental health Act. It means that we have to do it"

> "I think the psychiatrists are more structured now in their thinking because they know that they could eventually be working towards a

> CTO and they know that they're going to have to sit through a tribunal... They know they are not going to be asked by a Sheriff… they're going to be asked by a psychiatrist, a fellow psychiatrist about what they're doing" (R: 05 Mental Health Officer).

As can be seen from these comments by respondents (R: 10, 05 and 06) the law of unintended consequences can be seen at work in the bifurcation that occurs as a result of the distinction between formal and informal patients under the current mental health Act. The procedural requirements within the Act are intended to provide greater clarity and safeguards in respect to the rights of formal patients, not least with regard to the transparency of the treatment plan that forms the basis of the suspension of their civil liberties.

This has been described elsewhere as rather like the distinction between a champagne and white cider service (Atkinson, Lorgelly et al. 2007); from this perspective the non-detained population effectively become second-class citizens in the clamour for scarce resources. The use of champagne as a metaphor is however perhaps somewhat overoptimistic!

> "...the anxious avoidant personality disorder won't be thought about, or it will be sort of recognised but sort of in a ... mildly irritating way or more as a sort of therapeutic obstruction rather than something in and of itself that might need to be dealt with or helped ... I think there's a disappointing lack of interest in other personality disorders" (R 17: Psychiatrist).

The historical antipathy felt by clinicians towards those who attract a diagnosis of personality disorder is well established (Lewis and Appleby 1988). One of the potential unintended consequences therefore of the highly selective inclusion of borderline personality disorder, may be that service users interpret this as evidence of residual ambivalence towards them. The above comment by respondent (R:17) provides reason to believe that a degree of residual ambivalence towards those who attract diagnoses of personality disorder is still a practical reality with real exclusionary consequences.

> "...people (who attract a diagnosis of personality disorder) are left to the bottom of the pile, or the other response is to kind of throw one hundred and one services at somebody with personality disorder"(R 10: MHO and Practice Team Leader).
>
> "It's definitely the most least restrictive, most hands off that we can do with anybody with a personality disorder. But then on the converse side of the coin probably, if you've got somebody in a forensic mode, you're piling on maximum restriction because of the emphasis now, probably since Mr L. and Mr M. on public safety and lots of other cases as well" (R 10: Mental Health Officer).

> "(*Those who have a diagnosis of personality disorder and are most likely to get a service*) are those who hit the criminal justice system" (R: 28 Mental Health Officer).

These last comments by respondents (R: 10 and 28) shed light upon the distinction made in practice between those who attract a diagnosis of personality disorder and who are not perceived to represent a risk to others, and those who attract this diagnosis and are perceived to represent a risk to others.

> "In terms of personality disorder my experience recently has been risk has been to the fore, and I'm concerned we actually going further down the English model" (R: 11 Mental Health Officer).

This comment from an experienced MHO indicates that while Scotland has not embraced the DSPD gender being pursued by the UK Government, that the potential for drift towards a public protection rather than health driven agenda for those who may attract a diagnosis of personality disorder remains real.

These and other examples of 'sorting' can be understood as examples of the exercise of power through the application of scientific knowledge (Foucault 1982), such that people as subjects become turned into objects that can then be classified, sifted, ranked and so forth (Madigan 1992). A further example of this process that emerged during the course of this research resulting in the bifurcation, or the separating out of different groups of service users, is that of the distinction between forensic and non-forensic service users. There would appear to be a tendency by front-line workers to adopt very contrasting positions in terms of the intervention / restriction of liberty continuum, depending on which side of

the general / forensic dividing line any given service user who has attracted a diagnosis of personality disorder is positioned. The above comments from respondent (R 10) illustrates one of the unintended consequences of the clear divide between formal and informal patients within the current mental health Act: namely that the principle of adopting the least restrictive approach that is embedded within the legislation, has been used to provide a rationale and justification to legitimise this process of bifurcation based on the distinction between the general and forensic spheres.

Confidence, Competence and Cultural Change

Uncertainty and an apparent lack of confidence among some psychiatrists, regarding their competence to work effectively with service users who attract a diagnosis of personality disorder also emerged during the course of this research:

> "...doctors just don't know what to do, they're not necessarily trained to have that skill set" (R 04: Psychiatrist).

> "...we needed to understand how to help...but not sort of be blinded by oh well I am not a DBT therapist so I don't know what to do here" (R 17: Psychiatrist).

The emphasis often given to very specific therapeutic interventions such as Dialectical Behaviour Therapy, on the grounds of treatment efficacy, would appear to have the potential to create a degree of tension concerning who is qualified to work with service users who attract a diagnosis of personality disorder. These tensions are exemplified by the two comments above from respondents 04 and 17. Respondent 04 was sceptical about whether or not psychiatrists are sufficiently trained to work effectively with those who attract a diagnosis of personality disorder, whereas respondent 17 felt that psychiatrists were well-placed to make use of the insights and techniques used within approaches such as dialectical behaviour therapy, without necessarily being formally trained in its use and application.

> "...psychiatrists are not comfortable dealing with stuff that clearly isn't illness" (R 04: Psychiatrist).

> "...borderline personality disorder in particular is business for us" (R 17: psychiatrist).

These comments further illustrate the tension within psychiatry concerning the extent that those service users who attract a diagnosis of personality disorder should fall within the limits of the role and responsibilities of psychiatrists as health professionals operating within a medical paradigm. The debate concerning the proper extent of psychiatric involvement in the sphere of personality disorders can be understood in terms of cultural change, which by its nature is not linear and uniform but

contested and characterised by a degree of uncertainty. Certain psychiatrists clearly hold the view that there is no question as to whether or not they should be working with service users who have attracted a diagnosis of personality disorder; this view however appears to be confined very largely to the more specific diagnosis of borderline personality disorder.

> "I'm not trained properly in this risk document, I am not trained properly in suicide prevention, you know, in comparison to their health colleagues" (R 10: Social Worker and Practice Team Leader).

This comment from respondent (R 10) illustrates that anxiety regarding competence and training was however not limited to psychiatrists. This Mental Health Officer and practice team leader observed that social workers often expressed anxiety that they lacked training in comparison to health colleagues, particularly in the use of specific instruments and issues that were perceived to be especially relevant in working with those who have attracted a diagnosis of personality disorder.

Dissocial / antisocial personality disorder

Debate concerning whether and if so how, those falling within this diagnostic category should be included and provided with services continues:

> "(*I*) don't think there's any reason why we shouldn't be seeing antisocial personality disorder you know... obviously the percentage of prisoners with antisocial personality disorders is very high" (R 19: Psychiatrist and Key Informant).

> "...for people with, you know, antisocial and psychopathic PDs, then I think they probably don't have a place within psychiatry, you know within medicine and they're probably best dealt with legally" (R 02: Psychiatrist).

These responses from respondents (R: 19 & 02) both of whom are psychiatrists, illustrates that fundamental disagreement still continues regarding how those who attract a diagnosis of specific categories of personality disorder should be responded to. The established Scottish position, following the tragic events at the state hospital in the mid-1970s discussed earlier within the literature review, is that those who have attracted a diagnosis of dissocial / antisocial personality disorder fall outwith the province of medicine and therefore psychiatry: this contrasts strongly with the emphasis of recent years in England shaped significantly by the DSPD agenda. The established position of excluding those who

attract a primary diagnosis of dissocial / antisocial personality disorder from medical facilities including the State Hospital has been reinforced:

> "...they (*the MacLean Committee*)...took the view...that if you were a risk to the public and you've got a criminal background you should be in prison, you shouldn't be in hospital" (R 22: Key Informant - Member of the Millan Committee).

> "No, in fact, it doesn't happen at all (*the admission of those who attract a primary diagnosis of personality disorder to the state hospital*)... We think that they are better handled within the justice system... The current provision isn't adequate but the model is probably the right model" (R 14: Key Informant).

The above comments from respondents (R: 22 and R: 14) illustrate that the established Scottish position, endorsed by the MacLean Committee, favouring a corrections rather than healthcare based response to those within this group continues to be reflected within the approach favoured by the Scottish Government. During the course of this research however the established position within Scottish psychiatry of not working with those with dissocial / antisocial Personality Disorder was contested by one psychiatrist (R: 19), who can be reasonably said to be in the vanguard of moves towards greater inclusion as advocated by organisations such as the forensic network (Thomson 2005; Thomson 2008).

The above comment from respondent (R 22) however, sums up the position in Scotland concerning the maintenance of the established position of excluding those who attract a primary diagnosis of dissocial - antisocial personality disorder from a medical / healthcare approach in favour of a corrections model. The maintenance of this position was endorsed by the MacLean Committee as part of its rebuttal of the DSPD agenda. As discussed elsewhere within this thesis the position adopted by the MacLean Committee was particularly important, given that the Millan Committee were mandated to take account of any recommendations made by the MacLean Committee with regard to personality disorder.

Borderline Personality Disorder

During the course of this research it emerged that the growing emphasis upon borderline personality disorder has increased to the point where for practical purposes it has become synonymous with personality disorder more generally:

> "...we'll always get the border... whether the Act's there or not because of the way they behave and the difficulties they have" (R 02: Psychiatrist).

> "Personality disorder has almost become synonymous with borderline personality disorder (and BPD is becoming) core business for psychiatric services "(R 17: Psychiatrist).

> "...there's lots of services there for people with schizophrenia, quite rightly (*these tend to be*) vulnerable people (*with*) a 10% risk of mortality, frequent suicide (*who constitute*) roughly 1% of the general population and (*we have*) treatments that work, so it is appropriate to invest in that and support people...I think there's a slow, very slow shift round to thinking, actually borderline is about 1%, with a 10% mortality rate and... broadly speaking... a well established evidence for effective treatment, mainly DBT" (R 04: Psychiatrist).

The greater acceptance of the legitimacy of providing services for those who have attracted a diagnosis of borderline personality disorder would in part appear to be based upon growing evidence of their similarity with, rather than difference from other groups of service users with whom psychiatrists routinely engage. The narrow focus upon borderline personality disorder is also shaped by current evidence concerning treatment efficacy:

> "(*the diagnosis of borderline personality disorder)...* is the only condition that has an evidence base for treatment" (R 19: Key Informant and Psychiatrist).

However:

"...even that is a bit wobbly, but the others (*specific diagnostic categories of personality disorder*) just don't have anything" (R 19: Key Informant and Psychiatrist).

The process of adopting a more inclusive approach towards personality disorders is shaped by a number of factors, not least the availability of an evidence base to provide a rationale for engagement by health professionals. The highly specific inclusion of the diagnosis of borderline personality disorder, as distinct from personality disorders more generally, has been justified on the basis that this specific diagnosis has a developing evidence base. The robustness of this evidence base was however seen to be open to question; however in comparison to other personality disorders it is significantly more developed.

"...people haven't done the kind of research that things like integrated care pathways and NICE guidelines... require" (R 19: Key Informant and Psychiatrist).

"...they're a group that have generated a great deal of interest research wise as well in contrast with some of the other personality disorders and so there are evidence based treatments as well, and because they come psychiatrist's way and because psychiatrists... use drugs on them...drugs companies get very interested in them..." (R 17: Psychiatrist).

These comments from respondents (R: 19 and R: 17) illustrate that the emerging evidence base that has contributed to the process of inclusion is

not however neutral; rather it reflects in part the interests of researchers and those who fund research activities. Funding for research was to some extent regarded as being influenced by the potential market available to pharmaceutical companies, who were perceived as taking an increasing interest in borderline personality disorder due to the potential to provide some means of regulating the patterns of behaviour that are generally associated with this form of diagnosis. At a local level at least, certain behaviours stereotypically associated with the diagnosis of borderline personality disorder, have resulted in an increased expectation that health services will engage with service users who attract this diagnosis. This was noted by one respondent in connection with specific behaviours including:

> "...burning houses or threatening to throw themselves off the... Bridge" (R 17: Psychiatrist).

A financial imperative for restructuring services also emerged during the course of this research; given the current economic climate and emphasis upon austerity this may well become more significant:

> "...we did audit people with borderline a few years ago and roughly a sixth of our in-patients are in because of borderline. On average, they spend one year out of three, as an in-patient... So there is, if nothing else... a financial imperative for us to do what we can to re-provide in-patient services in the community..." (R 04: Psychiatrist).

The potential to restructure services in such a way that less in-patient beds are required represents a significant financial incentive to reduce the rate of admissions. Despite the on-going reluctance by some clinicians to work with those with personality disorders, in-patient beds still tend to be occupied to a significant extent by those with a comorbid diagnosis that includes borderline personality disorder. One respondent (R: 04) put this as high as one in six in-patient beds. Redesigning services so that service users can be better supported in the community, thereby reducing the need for admissions offers the potential for significant financial savings. Re-providing services in the community in such a way that does not lead to the needs of those who attract a diagnosis of personality disorder being further marginalised, highlights the need for the agenda of inclusion to be embraced more widely and readily by the full range of front-line staff.

Cultural Change

A picture of a partial cultural shift towards the inclusion of those who attract a diagnosis of personality disorder emerged during the course of this research; this was however tempered by a recognition that progress has to date been fairly limited:

> "I think over the years the profession has moved on a bit and I think is more comfortable with the nature of our involvement" (R 17: Psychiatrist).

> "I think that cultural change is very difficult to achieve and requires a lot of hard work, but once it's happened it perpetuates itself" (R 17: Psychiatrist).

The apparently slow rate of progress towards greater inclusion was not however seen by this respondent to be a cause for pessimism; rather on the contrary it was perceived as a long-term project that would ultimately prove successful. This gradual attitudinal change is underpinned by the blunt reality of the inclusion of personality disorder explicitly within the Act which means that:

> "...it (*personality disorder*) must be something to do with the mental health services and psychiatrists have to take it on" (R 19: Psychiatrist and Key Informant).

When a range of professionals were surveyed as part of the preparatory work for the establishment of the Scottish Personality Disorder Network, resistance to the move towards inclusion was however found to be strongest among psychiatrists:

> "...psychiatrists were the least positive" (R 19: Psychiatrist and Key Informant).

Whether or not they welcome it however; the majority of psychiatrists would appear to be moving towards a more inclusive position such that:

> "Even if they are reluctantly changing they are probably still changing" (R 17: Psychiatrist).

> "...people have to have eyes to see that the change is actually happening" (R 17: Psychiatrist).

The last of the comments above illustrates that one of the most crucial variables that is likely to influence how far and fast the process of including those who attract a diagnosis of personality disorder moves, will not so much be determined by definitions contained within legislation; but rather that the attitudes and disposition of clinicians towards those who attract this diagnosis is likely to be of central importance. The limited scope of the law to impact upon practice has been explored by Pilgrim (2012) in his discussion of the limits of legalism and will be discussed further later within this thesis.

Proponents of inclusion based upon incremental cultural change, regarded this as far more significant than resources per se:

> "... (*Inclusion is*) not about lots of money, it's about attitudes and culture and education and training" (R 19 Psychiatrist and Key Informant).

> "...we were invited down to the Department of Health to tell them how we managed to do so much (*with so little*)" (R 19: Psychiatrist and Key Informant).

The approach being pursued in Scotland is based on encouraging a change of attitude and approach amongst clinicians and the broader range of professionals who may be expected to work with those who attract a diagnosis of personality disorder: this approach was contrasted by respondent (R: 19) with that adopted in England, the latter being heavily influenced by the DSPD agenda that has involved very considerable financial investment with disappointing results (Tyrer, Duggan et al. 2010).

Cultural change was seen to have a wider significance beyond the specific inclusion of personality disorder, which was itself seen as part of a broader shift or realignment of the relationship between doctors and patients:

> "I think the reason it was included in the Act, was a reflection of the importance of ... a kind of shift in the doctor / patient relationship" (R 04: Psychiatrist).

> "I think the Act kind of marked that trend, which has continued to change. The change we might have seen since the Act came in and now, I don't think... I wouldn't say is really the Act" (R 04: Psychiatrist).

The process of inclusion can therefore be seen as encompassing the Act, rather than having a more direct relationship to it. The psychiatrist who offered this fairly positive view of the broader context in which any move

towards inclusion is taking place, also conceded that the change was to date very limited in scope, being confined almost exclusively to Borderline Personality Disorder:

> "(for) other forms of PD, particularly the Dissocial PD... I don't think practice has particularly changed but I think there is a... significant shift in the way people think about Borderline PD and that probably predated the Act (R 04: Psychiatry).

One psychiatrist who may be said to be championing the move towards the broader inclusion of those who attract a diagnosis of personality disorder, also expressed the view that positive changes were not particularly related to the Act itself; rather the changes that have taken place so far have:

> "...happened independently of legislation...the legislation is irrelevant to these issues" (R 19: Psychiatrist and Key Informant).

> "...it (*the explicit inclusion of personality disorder within mental health legislation*) hasn't made any difference...to be honest" (R 03: Psychiatrist).

> "No (*the explicit inclusion of personality disorder within mental health legislation*) it doesn't make any difference to have it included in the Act (R: 27 Mental Health Officer).

> "It hasn't changed, it is still seen by clinicians as not being a mental disorder despite the fact that it is included in the legislation" (R: 28 Mental Health Officer).

The process of inclusion was however perceived by one psychiatrist as dependent upon a change not so much in attitude among psychiatrists; rather the crucial change was on the part of the public because psychiatrists felt the need:

> "...to be given permission to become involved (in order to avoid the accusation that they were acting as) social police (*by*) medicalising everyday life and... being society's policeman" (R 04).

> "The key change on the Ward where staff start to get it about someone with very difficult behaviour who's got PD is when they see the person, I am sounding similar to the sort of See Me ad but when it clicks with them, that the reason they're doing this behaviour isn't because they're a nasty piece of work who's at it, but because they were so badly damaged during their upbringing that they don't know any other way to behave or can't respond differently" (R 04: Psychiatrist).

This optimistic view was uncharacteristic of comments offered by respondents in general, and can be contrasted with a view more typically expressed that once admitted those who attract a diagnosis of personality disorder are likely to be viewed with a certain degree of ambivalence or

possibly even hostility. This was exemplified by one MHO who described their experience of working with a particularly service user:

> "Due to the management difficulties that this young man represents, I get the distinct impression that he will be discharged as soon as possible (*because*) supporting him is such a management problem, so we still have revolving door patients" (R: 26 Mental Health Officer).

As discussed previously, a significant number of people who are admitted into psychiatric care are likely to meet the diagnostic criteria for a personality disorder; the approach adopted by Ward staff is therefore of particular importance in shaping how those who attract a diagnosis of personality disorder actually experience services:

> "...treatment, even though you've got a broader definition under the Mental Health Act, still means very specific things to them (*and psychiatrists*) may choose to ignore it " (R 10: Mental Health Officer).

> "...our job really (is) to look at medication" (R 02: Psychiatrist).

> "Treatment is very focused upon medication" (R: 28 Mental Health Officer).

A sense of frustration was expressed widely by MHO respondents at the reluctance to make use of a more expansive definition of treatment contained within current legislation. The following comment articulates this most clearly:

> "Health tends to be very prescriptive as to what fits into that small box (*what is treatable*), and it's a very small box" (R: 27 Mental Health Officer.

The traditional parameters of the medical paradigm create a degree of tension in terms of how the Act is interpreted. The Act contains an expanded definition of treatment that is intended to provide greater flexibility to clinicians; however the professional discretion available to clinicians and psychiatrists more specifically, means that those who wish to adhere to a more traditional interpretation of treatment are likely to be able to do so. Psychiatrists wishing to work in accordance with a more traditional interpretation of treatment, and by extension treatability, may be inclined to justify this by defining their role in terms of prescribing rather than taking a broader view.

> "...because people with PDs tend to present out of hours, you're more likely to see them (*as a junior Dr*) than when you're a consultant" (R 02: Psychiatrist).

This comment concerning service users presenting out of hours provides further evidence of the structural difficulties that emerged during this

research; these difficulties relate more broadly to the notion of service readiness. The specific issue being highlighted here is that the availability of those with the greatest degree of experience and expertise, are often least available when those who are likely to attract a diagnosis of personality disorder are most likely to present seeking assistance.

> "...still in lots of parts of the country (*problematic harmful behaviours are still not always*) ascribed to borderline personality disorder, partly because it was felt exclusive as a pejorative term" (R 03: Psychiatrist).

> "...my practice has changed and I haven't found anybody who hasn't welcomed the diagnosis, you know, where it is appropriate and where it's done in the proper way. Actually everybody we've discussed this with has found it helpful to be able to put a term around this particularly when you... have... a context that lets them access help" (R 04: Psychiatrist).

This view was echoed by a number of MHO's, the following observation is typical:

> "It's good that people are upfront, more upfront about the diagnosis. Prior to the new Act, it was often written in people's notes and not discussed with them…it was kind of undercover. Now I think… It is much more transparent but I think there is still the

> difficulty with people getting diagnosed…psychiatrists are reluctant to diagnose a personality disorder" (R: 05 Mental Health Officer).

Perhaps somewhat ironically given the acknowledged tendency for a diagnosis of personality disorder to act as a barrier to accessing services, it emerged during the course of this research that a reluctance to offer this diagnosis may itself hinder efforts by those who view this diagnosis positively as a gateway to greater service provision. Where practice has changed, resulting in a greater willingness to make and share this diagnosis with service users, this would appear to have been broadly welcomed. An important caveat within the last comment from respondent (R: 04) concerns the importance of making sure that once such a diagnosis is given that resources and sources of support are actually available. Offering a diagnosis of personality disorder without being able to also offer service responses that are considered meaningful and relevant, both to the clinician and service user, creates the risk of further alienating service users and adding to their distress. This acknowledges that being given a diagnosis of personality disorder is in itself a very significant life event for many service uses. In essence this argument extends the principle of reciprocity so that it precedes the point at which any formal intervention may commence. This has parallels with the debate that emerged following the introduction of the NHS and Community Care Act 1990, which increased the expectations of service users by placing a greater focus upon the assessment of their needs but was not accompanied by a commensurate increase in resources (Postle 2002).

The Tension between Rights and Resources

During the course of this research it emerged that concerns about the dangers of raising expectations to unrealistic levels impacted upon the work of the Millan Committee and further illustrates the limits of legalism.

> "...we had to be aware of what was available or what was likely to be available... I think we were rather cautious about saying that any member of the population or any patient or any prisoner... should have a right to a mental health assessment. Who's going to do it? (R 22: Key Informant and Member of the Millan Committee).

> "...we did make the point... that you could do anything you like with the legislation but it was the follow-up that mattered, and the vast number of people with mental health problems were not really interested in what was in the Act but they were interested in the services" (R 22: Key Informant and Member of the Millan Committee).

> "...it's a question of services rather than the law and therefore it becomes a question of resources and it becomes a question of all the other things that are competing all the time for expenditure" (R 22: Key Informant and Member of the Millan Committee).

The distinction between the law, and the resources and services that are actually provided was acknowledged as particularly significant by the

above respondent. This echoes previous observations identified among others by Postle (2002), concerning the ambiguities and tensions that often characterised the gap between the policy / legal framework and the reality of service provision as experienced by front-line workers. The last comment above from respondent (R 22) is consistent with the observation that within advanced liberal democracies legislation has increasingly come to fulfil a symbolic role (Fieschi 2006) intended to apply a degree of moral force, rather than providing a clearly mandated command function. This development within the function of law in advanced liberal democracies was explored by Foucault (Dean 1999) in his exploration of the transition from a primary reliance upon sovereign power to the process of normalisation as a means for regulating conduct. From this perspective legislation comes to serve a communicative function, intended to reinforce particular expectations in terms of attitudes and conduct. According to Foucault, among others , social workers and psychiatrists occupy key roles within the juridical institutions that "act as coordinating points for normalizing powers and governmental regulations" (Dean 1999:145). Building on the work of Claus Offe, Pilgrim (2012) has highlighted the role of the welfare system and those working within it as that of trying to mitigate the pathogenic consequences of the current organisation of industrial societies. The implications of this line analysis will be discussed further within chapter 8.

> "Everything's a battle trying to get a service for somebody with personality disorder" (R 10: Mental Health Officer and Practice Team Leader).

"...if you ask lots of psychiatrists, they'll say no, I don't treat borderline PD or we don't take in people with BPD" (R 04: Psychiatrist).

"I think we could do with some clarity to do with what we mean by personality disorder… That lack of clarity still leaves a loophole for clinicians to say that with personality disorder is not really anything treatable that I can offer so therefore there is not really a role for us as a team" (R: 27 Mental Health Officer).

"...our particular battle with housing is legendary" (R 09: Mental Health Officer).

"Everybody's reluctant to take responsibility (*for those who attract a diagnosis of personality disorder*) (R: 05 Mental Health Officer)

Despite some evidence of an increasing emphasis in practice upon inclusion for those who attract a diagnosis of personality disorder, social workers continue to encounter fairly entrenched attitudes that extend well beyond those professionals with direct responsibility for working with those who may attract a diagnosis of personality disorder.

"I have fought for about 12 months to get a psychiatrist to review him, just to review the medication and I've come up against, we don't want to break the routine" (R 10: Mental Health Officer).

The emphasis upon consistency and maintaining very clear boundaries when working with service users who have attracted a diagnosis of personality disorder is well documented (Alwin, Blackburn et al. 2006); it would appear however that at least on occasion, this emphasis on maintaining stability itself can lead to tensions concerning how the needs of service users can be most appropriately addressed.

> "...even though I suppose as an MHO, we are supposed to be involved in the treatment plan, I have not been really involved because they tend to arrive in the mail" (R 01: Mental Health Officer).

A broader tension emerged during the course of this research concerning the relationship between MHOs and psychiatrists; this centres upon the role and expectations of MHOs vis-a-vis their involvement and participation in the treatment planning process. MHOs still felt that their role was often perceived by psychiatrists as continuing to be one of getting on with the work that no one else wanted to do, hence they were often left to:

> "...pick up the chaos" (R 10).

The Twilight zone

During the course of this research it became evident that service users who have been given a diagnosis of personality disorder, or who are perceived to have personality traits that are consistent with this diagnosis are all too often regarded as unwelcome by those responsible for providing services.

> "...there's a lot of controversy about this diagnosis (*personality disorder*) and we often find that within the Team (*CMHT*), anyone who's got a diagnosis of personality disorder is kind of, eventually, filtered out" (R 10: MHO and Practice Team Leader).
> "...we get a lot of people referred to the Community Mental Health Team. They will get an initial assessment, and, you know, the term is kind of bandied a lot about that nurses or social workers or the psychiatrist will say, oh we've assessed this person and we think there's personality features or there's borderline personality traits, and that sort of strengthens the argument not to bring them into the teams" (R 10: MHO and Practice Team Leader).

> "...it (*a diagnosis of personality disorder)* does prevent...access to care sometimes...because if you hear somebody you know that has a comorbidity or personality disorder, you know they're going to be more difficult to treat" (R 02 Psychiatrist).

"There is still that view that personality disorder just takes so much time and what you do doesn't make any difference" (R: 27 Mental Health Officer).

"...what happens is that they're then pushed out of the Team and they're not really pushed anywhere...there's a general perception of, this isn't somebody that belongs anywhere" (R 10: MHO and Practice Team Leader).

"Because (*their behaviours*) are related to their personality disorder…I've seen paperwork where people have sat down and said this compulsory treatment order is not working (*because*) it is not touching this part of the person (*i.e. the underlying personality disorder that has been diagnosed*) and so therefore they allow it (the CTO) to lapse" (R: 26 Mental Health Officer).

A Twilight zone is defined as "a situation or conceptual area that is characterized by being undefined, intermediate, or mysterious" (O.E.D.). The response to those who attract a diagnosis of personality disorder discussed above, suggests that those who attract this diagnosis are vulnerable to being denied access to services on the basis that in some sense they do not have a legitimate claim to them. The consequence however is that they can then be left in an ill-defined area without alternative sources of assistance being put in place. It is therefore reasonable to characterise this position as somewhat like a Twilight zone characterised by ambiguity and uncertainty. This ambiguity and

uncertainty is likely to increase any sense of alienation, frustration fear and anxiety experienced by service users who find themselves in this very precarious position of not belonging anywhere.

Conclusions

The concept of personality disorder continues to invoke strong feelings, beliefs and attitudes among those who work with this group of service users. The field of personality disorder remains characterised by contested meanings, expectations and boundaries.

During the course of this research differing views emerged concerning how a more inclusive agenda for those who attract this form of diagnosis might be implemented. The clearest dividing line between proponents of greater inclusion was based on sharply contrasting views of the potential merits of developing more specialised services, or trying to re-orientate generic services to be more accepting of those who may attract a diagnosis of personality disorder. The emergent theme that arguably has the greatest significance for those who may attract a diagnosis of personality disorder concerns the distinction made in practice between borderline personality disorder and other forms of personality disorders. This distinction comes most clearly into focus with regard to the diagnoses of borderline personality disorder and dissocial personality disorder. In particular the very selective inclusion of the diagnosis of borderline personality disorder and de facto exclusion of those who may

attract a diagnosis of other forms of personality disorder. This process of bifurcation is likely to reinforce the suspicion and hostility that service users who attract a diagnosis of personality disorder have all too often encountered (Ferguson, Barclay et al. 2003). Further dividing lines were evident in terms of the potential for unintended consequences based upon the distinction between forensic and non-forensic service users and formal and informal service users.

The perception of those who attract a diagnosis of personality disorder as wearing a veil or mask, is likely to act as a barrier to accessing services as they are more likely to regarded as not sufficiently service ready: the practice of terminating contact following the 'failure' to keep appointments is an example of the lack of fit between the expectations of those providing services and the capacity of those seeking or needing them to act in the required manner. The subcontracting out of services by the statutory to the voluntary sector has been used in part to allow statutory services to distance themselves from those who attract a diagnosis of personality disorder. Service users who attract a diagnosis of personality disorder continue to be admitted to inpatient care; however once admitted they may well experience a degree of hostility and resentment because of the perceptions of staff that there is lack of fit between their needs and those who fall more squarely within the diagnostic and treatment framework of the medical paradigm.

The on-going degree of ambiguity concerning the status of those who attract a diagnosis of personality disorder and ambivalent responses to

them, mean that service users who attract a diagnosis of personality disorder may continue to occupy a space within the sphere of service provision somewhat like a twilight world of half recognition and acknowledgement. The reluctance of some professionals to engage with, and tendency to disengage from working collaboratively with other professionals in respect of those who attract a diagnosis of personality disorder, emerged as an on-going issue for front-line workers during the course of this research.

Increasing moves towards specialisation create the possibility of further unintended consequences, due to the disruptive effects of specialisation upon maintaining effective service interfaces: any loss in the effectiveness of these interfaces is likely to mean that those who attract a diagnosis of personality disorder are particularly vulnerable to falling through the gaps between specialisms and boundaries between services. If they are to be successful, nascent efforts to re-provide services for those who attract a diagnosis of personality disorder in the community, will require a broad range of support from those professionals involved and those responsible for planning and resourcing community-based services. Changes in the responses by front-line workers towards those who attract a diagnosis of personality disorder, and changes in the manner in which services are provided appear to be quite limited.

Changes in attitudes and practices, where they are evident, appear to be developing independently of the decision to retain personality disorder within mental health legislation in the Mental Health (Care and

Treatment) (Scotland) Act 2003 following its explicit inclusion by means of the emergency legislation of 1999. The implication is that to some extent at least, the explicit retention of personality disorder within the 2003 Act can be regarded as more symbolic than intended to drive forward actual changes in how the needs of those who attract a diagnosis of personality disorder are understood and addressed. A tension emerged in the course of this research between a reluctance by psychiatrists on the one hand to make a diagnosis of personality disorder, on the grounds that this may hinder service users from gaining access to services, contrasted with a change in practice by some based on a greater willingness to be open with service users when making this diagnosis. The important caveat being that a shift in practice based upon a greater willingness to be open about diagnosis needs to be accompanied by an appropriate follow-up response, so that the needs of service users can be appropriately acknowledged and addressed. During the course of this research, on-going tensions were evident concerning whether or not those who attract a diagnosis of dissocial / antisocial personality disorder should be brought within the sphere of healthcare, or continue to be dealt with outwith this sphere within criminal justice settings in accordance with a corrections model.

During the course of this research it became clear that attitudes towards those who attract this form of diagnosis continue to be contested, with evidence of a desire by some to adhere to a traditional position, based on a fairly narrow interpretation of treatment and of their role as primarily that of prescribing medication, contrasted with those who were more

willing to accept the more sweeping definition of treatment contained within this legislation. Where attitudes have however changed in favour of a more inclusive approach, this almost exclusively concerns borderline personality disorder: while this is likely to be welcomed by some this particular emphasis may have the effect of reinforcing the de facto exclusion of those who attract a diagnosis of any other form of personality disorder. Service responses to those who attract a diagnosis of personality disorder do not appear to have substantially changed; however this may be partly explained by the absence of services that can be readily utilised by those who attract this diagnosis and made use of by those who would wish to make referrals to them.

The availability and access to services does not appear to have significantly changed either as a consequence of this legislation or as yet more broadly because of cultural and attitudinal changes among front-line workers. As noted by respondent (R: 22), it is not changes to the law that are ultimately important; rather it is the actual availability of resources and services.

The decision to maintain the inclusion of personality disorder within mental health legislation in Scotland as expressed within the Mental Health (Care and Treatment) (Scotland) Act 2003, serves more of a symbolic function than operating as a direct driver for changes in working practices. It is likely that for the foreseeable future those who attract a diagnosis of personality disorder will continue to find accessing appropriate services very problematic: those seeking to provide services

for those who attract a diagnosis of personality disorder are likely to experience their endeavours as an on-going battle in the competition for resources. Service users who attract a diagnosis of personality disorder continue to be caught in a web of contested meanings and competing imperatives.

The emergent themes that have been explored within this chapter are underpinned by dividing lines that have the clear potential to take the form of battle lines in the struggle for resources and on-going tensions concerning how far the process of inclusion should be extended. While the characterisation of service responses referred to previously as those of champagne or white cider, may be too optimistic on the one hand it may be all too realistic on the other. Those who attract a diagnosis of personality disorder are likely to continue to occupy a twilight zone in which they are at best, offered partial recognition and acknowledgement.

Chapter 7:

Resources and Needs - Implications for Practice

This chapter will primarily focus upon my fourth research question namely:

'In what ways has current legislation influenced the availability of services for those who attract a diagnosis of personality disorder'?

During the course of this research among the key themes to emerge, were those of the central importance of how the needs of those who may attract a diagnosis of personality disorder can and should be met, and how resources should be understood and allocated. The key themes that will be explored in this chapter include the tension between public / private sector provision, the potential significance of the Scottish Personality Disorder Network and specific factors impacting upon access to services. Having considered the significance of attitudes, expectations and boundaries in a previous chapter, this current chapter will focus more specifically upon how the needs of those who attract a diagnosis of personality disorder are understood and the availability of resources to address these needs.

Need, Presentation and Perception

How the needs of potential service users are perceived and their claims upon services responded to can have a profound effect upon their well-being:

> "I think the way the system responds to people almost provokes them to maybe do worse things or present on a more frequent basis because they feel like that's the only way people will recognise how much distress and how much trouble they are having…you kind of get locked into this kind of vicious circle" (R 18: Informant and Service User).

> "I would like people to actually listen to what I was saying (rather than) through the sort of filter of their diagnosis, rather than as an individual" (R 18: Informant and Service User).

> "...people get accused of being dependent on the service and playing up to their diagnosis and all this kind of stuff, whereas I think that's actually a response to the way the system is set up, and that it has been quite dismissive of their issues in the first place.....the threshold of risk to self-harmers seems to be incredibly high. You know, you are told self-harming, that's not a very intelligent thing to do, is it? Why were you doing that? If you are going to do that, go to a different hospital - that kind of thing.....(*the*) *approach* to self-harm (*is not the same as*) maybe

> ten years ago, but it's not across the board, it's a bit luck of the draw...(R 18: Key Informant and Service User).

Evidence of a residual antagonism towards those who may attract a diagnosis of personality disorder was acknowledged by a broad range of MHO respondents. The following comment expresses this particularly clearly:

> "…some people think they're just doing it for attention and…so there is a lot of debate and people get quite extreme views…thinking they actually know what they're doing… The word they often use is manipulative" (R: 05 Mental Health Officer)

This respondent echoed the comments offered by a number of MHOs that ambivalence towards those who attract a diagnosis of personality disorder was something they still frequently encountered in working with nursing staff:

> "…some of the nurses are quite upfront (*in saying*) I don't like working with them, don't like them, they're trouble I don't want to work with people with personality disorder…because it's not seen to be a real mental illness (*and therefore not part of their role*)" (R: 05 Mental Health Officer).

Service responses such as those described above by respondents (R: 18 & 05) would appear to be incompatible with one of the oldest tests of

professional ethical conduct, namely that of non-malfeasance (Banks 2012). The process of identifying and meeting human needs is framed within a range of tensions, competing interests and imperatives. The above comments from a service user and informant, illustrate that these tensions are perhaps more evident in discussions concerning those who may attract a diagnosis of personality disorder, than for any other group of service users. These comments also illustrate that the needs of those who may have attracted a diagnosis of personality disorder are all too often overlooked by a focus upon the difficulties that the behaviour being exhibited represents to workers. One of the perverse consequences of this is that the behaviours that are perceived as so troublesome can all too easily become amplified as the underlying needs of the service user remain unmet and therefore exacerbated.

The Public and Private Provision of Services

The tension between the public and private provision of services has been a key feature of policy debates since the introduction of the concept of the purchaser provider split within the community care reforms of the early 1990s. These tensions emerged as of clear relevance to debates in Scotland concerning how services for those who may attract a diagnosis of personality disorder should be provided:

> "I get a request about once every three or four months for a meeting with... one of the private sector providers from south of the

> border who would like to come to Scotland and start opening... 20 or 30 bed personality disorder units" (R 14: Key Informant - The Scottish Government).

The pressures exerted in favour of the marketisation of services is considerable, not least because it is one of the key mechanisms of managing the inherent contradictions that arise from the role of the welfare state in mediating between the subsystems of capitalist production and exchange relationships and the subsystem constituted by structures of socialisation (Pilgrim 2012). Although not directly applicable in Scotland, the Health and Social Care Act 2012 gives very explicit impetus to the marketisation of healthcare provision. Given the current funding relationship between Scotland and the rest of the UK, the pressure for policy within Scotland to move in this direction is likely to increase.

The above comments of Key informant (R: 14) underscore the extent that policy, law and practice, should be contextualised within a broader arena in which mental health disorders have become a major growth opportunity for private sector providers in England and a number of other jurisdictions. The impact of mental illness / disorder within advanced economies has been costed at between 3% and 4% of GDP (W.H.O. 2003), thereby potentially creating a very significant market opportunity that will include the provision of services and treatments in respect of personality disorders. The cost of private provision per person per year is estimated by this respondent to be:

> "Somewhere around £130,000 to £150,000 per year, a place" (R: 14 Key Informant - The Scottish Government).

The potential impact of increasing the range of service provision upon the health budget in Scotland should therefore not be underestimated. Service providers are currently experiencing the impact of an increase in expressed need (Bradshaw 1972) as a result of greater awareness among service users of what services are available elsewhere as information, whether reliable or not, becomes increasingly accessible. Service users and carers are able to identify the apparent availability of private provision when they:

> "...go away and look up the Internet and find…units down south" (R 03: Psychiatrist).

This causes an added degree of tension in the relationship between service providers and service users and carers because in general:

> "...the Health Board won't fund it" (R 03: Psychiatrist).

The costs of this private sector provision are generally regarded as prohibitive by health boards within Scotland: this increases the sense of frustration amongst service users who believe that they are likely to benefit from and should therefore be entitled to such provision. This problem is compounded by the promotion of private sector provision that has the effect of creating demand that cannot then be satisfied.

The Availability of Services

Given that receiving a diagnosis of personality disorder is of itself likely to be highly momentous for the majority of people, the need for appropriate services, delivered by properly trained workers in a timely manner is of great importance. During the course of this research clear difficulties emerged concerning all three of these criteria:

> "We don't have access to a great deal of psychology... I think they're (*psychiatrists and psychologists*) a bit dismayed because they realise the resource implications and so to date, I would say there's been a bit of a reluctance to kind of engage with that and start to open up to be accepting" (R 01: Mental Health Officer).

> "If you think of trying to access DBT from this team...I don't know why you would go quite honestly, I mean, our psychology service is inundated" (R 10: Mental Health Officer).

> "(The lack of services for those who may attract a diagnosis of personality disorder results in practitioners)... Trying to cobble something together with what we've got available, which is unsatisfactory (and leads to the creation of a) postcode lottery" (R 03: Psychiatrist).

> "…it depends a lot on whether or not the, you know on whether or not you've got a psychiatrist who's actually interested in working

with somebody with personality disorder in the first place" (R: 06 Mental Health Officer).

"...the patients get a....poor service really, because of lack of resources" (R 03: Psychiatrist).

When asked about what additional resources had been made available to help make the process of inclusion a reality for those who attract a diagnosis of personality disorder, the response was almost universally one of little or nothing:

"I can't think of anything that has been changed that would (*help us to*) accommodate this group" (R: 26 Mental Health Officer).

The above comments from respondents (R: 01; 10, 03, 06 and 26) are testimony to the patchwork nature of current service provision for those who may attract a diagnosis of personality disorder. The efficacy of treatment interventions for personality disorders continues to be contested; however the increasing although heavily caveated acceptance that in some circumstances, some of those who attract a diagnosis of personality disorder may benefit from specific treatment interventions (NICE 2009), may create the expectation among service users and also some professionals that additional services should be provided. The evidence that is available for treatment effectiveness, emphasises the importance of a structured and integrated approach to psychological and drug-based therapies in order to alleviate and manage distressing

symptoms that are associated with the diagnosis of personality disorder (NICE 2009).

Interventions such as dialectical behaviour therapy (TSG 2008) and cognitive behavioural therapy have become established as the primary psychological interventions for those who attract a diagnosis of personality disorder, most notably borderline personality disorder (Palmer, Davidson et al. 2006).

> "... I wouldn't like to go as far as to say it is emperor's new clothes but smoke and mirrors definitely" (R 12: Key Informant and Psychiatrist).

> "... (*CBT and DBT are*) not much different to what the psychoanalytical psychotherapists started from" (R 12: Key Informant and Psychiatrist).

These comments from respondent (R: 12) who was in a position of strategic oversight and a key budget holder, indicate however that the extent that approaches such as DBT should be regarded as advances in treatment is by no means settled. During the course of this research it became clear therefore that not only is the effectiveness of available interventions subject to on-going debate but that some of the treatments most commonly advocated are contested at a fundamental level.

Access to services

During the course of this research boundary disputes between services and what might be understood as territorialism emerged as significant obstacles to service uses accessing services:

> "...there are a lot of issues around whether you are stable enough to use (a) service, but the difficulty is people won't refer you for something you might get in two years because you are not stable enough now and people have been turned down for assessment on the grounds that they are not stable enough and, you know, the argument of people obviously coming back with how on earth do you know I'm not stable enough if you've never met me? (R 18: Key Informant and Service User).

And:

> "... it's extremely difficult to access the service because the statutory services won't treat the sort of personality disorder issues until you have sorted out the substance abuse problem, and a lot of substance abuse services either won't, or really struggle to help sort it out because obviously it's all intertwined, and it seems to me there just doesn't seem to be an awful lot of meeting of minds to try and solve all of these, to accept that all of these things are part and parcel" (R 18: Key Informant and Service User).

"...people still bounce about" (R 03: Psychiatrist).

"(*People who have been given a diagnosis of personality disorder*) get kind of bumped…bounced about between social work and health" (R: 05 Mental Health Officer).

From the above comments by respondents (R: 18,03 and 05) it is clear that one of the potential consequences of this on-going territorialism and boundary disputes may be that service users who attract a diagnosis of personality disorder, may continue to find it particularly difficult to access appropriate services in a timely fashion.

The restructuring and withdrawal of services has had a significant impact on service provision for certain groups, notably those who fall within the forensic sphere. An example of this was provided by one respondent in commenting upon an early intervention scheme that had subsequently been dismantled. The purpose of the scheme was:

"... to offer a service to the courts and it tended to be low-level offending where there was a mental health dimension, and the mental health dimension being...that it would not require the Mental Health Act but there were concerns around some aspect of the offender's behaviour, presentation, whatever. And so we were getting quite a lot with low-level personality disorders rather than, you know, psychopathy and high end other ones" (R 25: Mental Health Officer and Practice Team Leader).

"...that's no longer available, so a service that was available and met the needs of people suffering from personality disorders that the court could use, instead of imposing a harsher sentence, has been withdrawn" (R 25: Mental Health Officer and Practice Team Leader).

"So there's no Diversion from Prosecution scheme in Glasgow anymore which was one of our prides and joy" (R 25: Mental Health Officer and Practice Team Leader).

"Yes, you're keeping people out of the system, you're addressing their mental health needs, you're looking at their life and social needs, you know? And that's been totally withdrawn now. There's no funding available for diversion under the funding routes of criminal justice, so it's not a priority and there is nothing there. But, similarly, within a deferred sentence scenario that we offer to the courts, there has been nothing. So what, in terms of the lower level mentally disordered offender, you are left really with a criminal justice worker to carry a Probation Order who has the knowledge, the time to tie into the appropriate care pathway, which they wouldn't know anyways" (R: 25 Mental Health Officer and Practice Team Leader).

"... what's tending to happen just now is square pegs in round holes in terms of resource allocation" (R 25: Mental Health Officer and Practice Team Leader).

Given the evidence of the over-representation of those with mental health problems in the criminal justice system (Royal College of Psychiatrists 2007), then the need for effective early intervention and diversion from prosecution is clear. Those with a diagnosis of personality disorder may be even more likely to receive a justice based response, because of the historical reluctance to permit personality disorder to be used as a mitigating factor (Darjee and Crichton 2003). Recent case law however suggests that Scotland (HMA v Theresa Riggi 2011) is moving closer to the position that has pertained in England for some time, where in certain circumstances personality disorder has been accepted as a basis for a finding of diminished responsibility (Crichton 2004). This development however represents a double-edged sword, in that a diagnosis of one or more personality disorders remains profoundly stigmatising (Stalker, Ferguson et al. 2005).

Resources and the Scottish Personality Disorder Network

The Scottish Personality Disorder Network was established in 2006 following the successful efforts by a small number of clinicians to gain the support of the Mental Health Division of the Scottish Government. Its mission was and remains that of promoting awareness of personality disorder and challenging stigma associated with this form of diagnosis (The Scottish Government 2006).

> "...there wasn't any money to do very much, but (there) certainly wasn't going to be any new personality disorder services and so I think the best they could come up with was really looking at developing a network" (R: 16 - Key Informant: Voluntary Sector).

> "...resources are not always money, and one of the things that has happened with the personality disorder network is in getting involved with the integrated pathways and raising their profile" (R 19: Key informant and Psychiatrist).

The development of the Scottish Personality Disorder Network can be viewed as an example of the use of network capital (Swart 2006). This network is intended to harness intellectual and human capital to facilitate knowledge sharing and production across a range of stakeholders of differing backgrounds, disciplines and levels of expertise. Such an approach has the potential to create a degree of momentum to influence practice that transcends formal regulations and guidelines. The extent to which this is achievable however will substantially depend upon how the network is perceived. During the course of this research two contrasting views emerged of the potential significance of this network. The comments above from respondents (R: 16 and 19) indicate that the development of a network approach can either be viewed as a poor substitute for additional resources; or alternatively as the creation of a network capital resource that offers an effective way of sharing knowledge, good practice and increasing the profile of personality

disorder. The primary focus upon a network-based approach has meant that:

> "...we've not put in bespoke services for people with personality disorders (R 12: Key Informant and Psychiatrist).

Whatever the merits of a network led approach, resource constraints would appear to be acting as a driver to further change in practice:

> "...there's a financial imperative for us to do what we can to re-provide in-patient services in the community" (R 04: Psychiatrist).

This has resulted in a greater focus on community-based services meaning that:

> "...we've closed beds (resulting in a) natural experiment" (R 04: Psychiatrist).

> "… the person that they (*workers in a community mental health team*) go to for specific advice) (*is not someone*) they can refer to (*even though they*) are a personality disorder specialist…they might give you some advice but they'll not take a referral" (R: 11 Mental Health Officer).

The availability of services from those with specific expertise in working with those who attract a diagnosis of personality disorder would therefore

appear to be an on-going and significant issue. Professional expertise constitutes a specific form of human capital (Curtis, Moriarty et al. 2011). The emphasis upon consultation can be understood as a particular means of deploying this capital / resource in a manner that is intended to rationalise costs. A potential difficulty with such an approach is that those who may require the most knowledgeable and skilled support from social workers and other professionals, may be more likely to receive a 'diluted' service that is insufficiently responsive to their needs.

As services seek to cope with increasing levels of demand another theme that emerged in the course of this research was a tendency for those with the greatest expertise to draw back from direct service provision. This was felt to have particular implications for other professionals who increasingly:

> "...are expected to do absolutely everything" (R 20: Key Informant).

These comments indicate that the process of rationing may be being used to manage the potential demand upon clinicians' time. It is clear that this is not intended to constitute a form of active exclusion based on the notion of deserving and undeserving; rather it is a pragmatic response to the mismatch between supply and demand. Whatever the intention the practical reality for many of those who may attract a diagnosis of personality disorder, is that they may then subsequently be left without the follow-up or support that they may regard as necessary, thereby

increasing their subjective distress and sense of marginalisation. The lack of readily available expertise can have a range of unintended consequences including those relating to the assessment and management of risk:

> "...we had a very tragic incident...resulting in somebody's death...when we began to look at it...the patient had not been seen by anyone other than a junior doctor. And when we looked at the caseloads the consultants were carrying (we found) caseloads of 500 and upward"(R 12: Key Informant and Psychiatrist).

> "...we looked at that and tried to alter practice because we thought that was really dangerous. So yes there will be... A targeting in that way because there's finite resources"(R 12: Key Informant and Psychiatrist).

These comments illustrate the inherent problems associated with filtering claims upon services in an effort to manage demand. Perhaps the best that can be achieved when such an approach is adopted, is that of more accurately targeting or filtering demands in such a way as to minimise the risk of adverse outcomes for service users.

> "...I think what happens...in terms of clinical practice there is a whole host of people out there that if we were to do a clinical diagnostic interview with them, I think they would meet the criteria for one or the other or more of a personality disorder.....I think

> there's a reluctance for medical staff, nursing staff to put that label on people, and you can debate the pros and cons of that until the cows come home. So I think that's one thing, there's a whole range of people that would be avoiding personality (disorder)" (R 20: Key Informant).

Concerns regarding the inability of overstretched services to adequately meet potential demand emerged as a significant theme during the course of this research. The challenge represented in meeting the potential demand was summed up by one respondent who observed that the potential number of those who might attract a diagnosis of personality disorder was:

> "...just enormous, and it's too big a number, it's unmanageable really" (R 20: Key Informant).

The above comments reflect an underlying anxiety that became clear as this research progressed, namely that the greater inclusion of personality disorder might raise expectations of a more substantial level of service provision among those who attract this form of diagnosis and their carers. The potential discrepancy between increased expectations and scarce resources may mean that policymakers and service providers view it as necessary to take measures to ensure that the floodgates are not opened, thereby running the risk of overwhelming services. The potential for very considerable demands upon services to be created by the adoption of a genuinely inclusive approach towards those who attract a diagnosis of

personality disorder, is well illustrated by the findings of a recent report concerning the allocation of resources within the NHS in England (Centre for Economic Performance 2012). This report indicates that within England the percentage of the population that are deemed to be "diagnosable" for personality disorder, including borderline and antisocial personality disorder is 0.7% of the adult population: of this number only 34% are actually receiving treatment. Assuming that the prevalence rates are not substantially different between Scotland and England, then the potential number of those who might attract a diagnosis of personality disorder is quite considerable. Based on population size approaching 5 1/2 million the figure for those who might be deemed to be diagnosable would approximate 385,000.

> "I think people have been more aware, I think especially people who have been diagnosed more recently have been really shocked at the fact they have struggled to access treatment or they have been put on these enormous waiting lists" (R 18: Key Informant and Service User).

The current emphasis upon austerity would suggest that the experiences of service users such as those reported by this Key Informant are likely to become more rather than less common. This has the potential to further marginalise and exclude a group of service users who are already systemically neglected.

When services are not able to respond promptly and sensitively to the needs of service users, this inevitably exacerbates any feelings of alienation and distress that they may experience. Those who attract a diagnosis of personality disorder are more likely to face delays in being able to access services because of the relative status of this diagnosis when compared with those that fall within the category of severe and enduring mental illness in:

> "...a sort of pecking order. Personality disorder...comes bottom after everything else...(R 18: Key Informant and Service User).

The notion of there being a hierarchy of importance among those falling within different diagnostic categories was widely acknowledged by the majority of MHOs and psychiatrists alike, thereby reflecting the observations of the service user and key informant noted above:

> "(*people who attract a diagnosis of personality disorder are*) not seen as being the biggest / highest priority" (R: 05 Mental Health Officer).

One of the potential unintended consequences of this pecking order is that service users are effectively encouraged to escalate problematic and potentially harmful behaviours in order to move up the rankings based on risk rather than relying upon appropriate responses to their needs.

Conclusions

For those who may attract a diagnosis of personality disorder the manner in which their needs are understood and resources are defined and allocated, reflect a range of competing interests and are subject to on-going debate. The provision of services for those who attract a diagnosis of personality disorder is problematised by on-going uncertainty regarding the efficacy of available treatments as well as more fundamental questions concerning the legitimacy of this diagnostic category itself.

The moral imperative to meet human needs is reflected in a broad range of policy documents that give prominence to the notion of well-being. In practice however this moral imperative often appears to be outweighed by more practical considerations, for example concerns about services being inundated with demands that would overwhelm them. Service users are to some extent caught in the middle of the tension between the public and private sector provision of services. The apparent availability of services for those who attract a diagnosis of personality disorder in certain other parts of the United Kingdom, serves to raise expectations that are often frustrated because funding is not available for equivalent provision in Scotland, or to support services being accessed from elsewhere in United Kingdom. Private sector provision in particular is very expensive and has the potential to place a particularly severe demand upon scarce resources. Favoured models of practice such as dialectical and cognitive behavioural therapy have a growing but contested evidence base: their efficacy is insufficiently clear in the view of at least one budget

holder in a pivotal position to oversee and commission services. Waiting times and obstacles in moving between services continue to result in service users "bouncing about" rather than moving relatively seamlessly between services. The extent to which the Scottish Personality Disorder Network, as an example of the utilisation by policy makers and some practitioners of network capital, will be able to exert a significant influence upon practice in the future at this time remains to be seen. The role of expert knowledge emerged as a particularly important theme during the course of this research: it became clear as this research progressed that respondents felt that due to increasing demands upon services, that those with the most expertise were increasingly withdrawing from direct service provision themselves and offering a supervisory and consultative role instead. Service users who may attract a diagnosis of personality disorder continue to do poorly in the pecking order of the competition for scarce resources to meet pressing needs.

Chapter 8:

A Response to an Unruly Population - the Inclusion of Personality Disorder in Law and Policy in Scotland

Introduction

The focus of this chapter concerns the legal, policy and regulatory framework underpinning the inclusion of those who attract a diagnosis of personality disorder in Scotland. The implications of the manner in which the policy of inclusion emerged and has subsequently developed within policy and regulatory frameworks will be discussed. This chapter will therefore primarily address my second research question:

> How does the inclusion of personality disorder within mental health law fit into a broader range of strategies of control and regulation characteristic of an advanced liberal democracy?

Three imperatives emerged during the course of this research that created a particular series of tensions that underpin the current position regarding the inclusion of those who attract a diagnosis of personality disorder within Scotland. The first arises as a consequence of the established position in Scotland of not admitting those who attract a primary diagnosis of personality disorder to forensic psychiatric settings; the second concerns the political imperative for governing political parties to retain their legitimacy by being seen to be able to maintain order, and

the third arises from a recognition of the aspirations of those who attract a diagnosis of personality disorder to be included within service provision. The consequences of the manner in which these different imperatives interact with each other in law, policy and practice will be explored within this chapter.

These tensions are evident in the process of moving from an initial position of broad-based inclusion, implied by the term personality disorder, to the much more limited focus upon those who may attract a diagnosis of borderline personality disorder. Consideration will be given to the further narrowing of focus, exemplified by the omission of personality disorder from the Health, Efficiency, Access and Treatment target – hereafter referred to as HEAT target for waiting times for psychological therapy. This development within the policy framework has the potential to reinforce the position of those who attract a diagnosis of personality disorder as marginalised and excluded. Decisions made by those responsible for planning service provision and allocating resources provide the context in which decisions regarding who should receive services and on what basis are made: consequently the importance of the policy framework as distinct from legislation itself is difficult to overstate.

The policy framework and manner in which it is implemented at a local level, steered by regulatory devices such as HEAT targets, sets the context in which front-line practitioners are required to make decisions concerning how they should respond to those seeking services who may attract a diagnosis of one or more personality disorders. The extent that

those who attract a diagnosis of personality disorder are likely to find that such a diagnosis continues to be one of exclusion, or alternatively one that provides a gateway to appropriate service provision will therefore depend to a significant extent upon how inclusion itself is embedded within and expressed through policy frameworks and guidelines.

Political Imperatives and the Force of Realpolitik

The practical considerations of the policy-making process emerged as of particular significance during the course of this research. This reflects the reality that changes or reversals to legislation create a range of problems that need to be managed in order to minimise the risk of calling into question the legitimacy of the decision-making process itself (Patty and Penn 2011):

> "...once you had it (personality disorder) in the legislation (Mental Health (Public Safety and Appeals) (Scotland) Act 1999) it was very difficult for new legislation to say we should take that out again. If it hadn't been for the 1999 Act... I think the chances were that personality disorder wouldn't have been in our report as a recommendation... we had evidence which argued both ways but I think the committee at the end of the day, this was something that we had great difficulty in recommending. I think if it hadn't been for the 1999 Act which we suggested should be abolished then that

might have been different" (R: 22 Key Informant - Member of the Millan Committee).

"We (the Millan Committee) didn't like the 1999 Act, and in fact we wrote to the ministers saying that they panicked, basically what happened with the Ruddle case... they panicked... because of the tabloids and all the rest of it and also because of all the stuff that there'd been in England about dangerous mentally disturbed people committing murders" (R 22: Key Informant - Member of the Millan Committee).

The above comments from Key Informant (R: 22) are noteworthy not least because this respondent also played a significant role in drafting previous legislation. It emerged clearly during the course of this research that whatever the specific arguments for and against the explicit inclusion of personality disorder within mental health legislation; that the practical reality was that reverting to the previous innominate (Darjee and Crichton 2003) status of personality disorder that characterised mental health legislation prior to the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, was simply not a practical possibility. This interpretation is consistent with an acknowledgement contained within the Millan Report itself:

"...it would not be realistic to ignore the fact that the 1999 Act has given new emphasis to the question of personality disorder (Millan 2001):44.

The emergency legislation is of considerable importance, not least because it was the first legislative act of the reconstituted Scottish Parliament - this is consistent with the expectation that in order to be regarded as competent, particularly when faced with a crisis, governments must first demonstrate that they are able to maintain order and therefore maintain their legitimacy (Offe 1976).

Diagnosis, Risk and Dangerousness

The policy of the UK Government being pursued at the time that the reform of mental health legislation in Scotland was being debated was predicated upon the spurious intertwining of mental disorder, criminality, risk and dangerousness exemplified by the construct 'Dangerous and Severe Personality Disorder'. This caused a number of tensions that emerged during the course of this research:

> "(The MacLean Committee)...disliked the reference to personality disorder actually being mentioned in their terms of reference and effectively in their report they said it was not helpful. They wanted to focus on risk to the public and that was the main consideration" (R 22: Key Informant -Member of the Millan Committee).

> "... they (the MacLean Committee) also I think took the view, as a lot of people in the field did, that if you were a risk to the public and

you've got a criminal background you should be in prison, you shouldn't be in hospital" (R 22: Key Informant)

"I think England's included it (personality disorder) because of the... more...anti-social side than the emotional unstable side" (R 02: Psychiatrist).

and

"...it was the Home Office rather than the Department of Health that's obsessed with this (the inclusion of personality disorder in mental health legislation) in England" (R 22: Key Informant - Member of the Millan Committee).

"...the Home Office was...obsessed by this concept, and the result is that they couldn't get legislation" (R 22: Key Informant - Member of the Millan Committee).

"The English committee that was set up to look at the English legislation at the same time as our committee was established, got kind of instructions from ministers as to some of the things that they could do and some of the things they couldn't do. There's no way in which the Scottish Office, as it was before, and the Scottish Executive would have given us instructions or would have tried to give us instructions" (R 22: Key Informant - Member of the Millan Committee).

> "...in Scotland I think there's much more of a feeling that psychiatrists are actually to some extent involved in the political process and we actually have a political voice in Scotland and we are not excluded from government (in contrast to England therefore) the political process for psychiatric reform in Scotland has been much better" (R 17: Psychiatrist).

The above comments suggest that the ability of psychiatrists within Scotland to influence the political process may to some extent explain why in Scotland the policy of not admitting those who have attracted a primary diagnosis of personality disorder to forensic psychiatric units has been maintained, in sharp contrast to the position that has developed in England. The Millan Committee was required as part of its remit, to take account of the findings of the MacLean Committee as far as it may make any recommendations in respect of personality disorder. The apparent reluctance of the MacLean Committee to specifically address personality disorder is therefore of particular interest.

The MacLean Committee (2000) indicated their discomfort with being asked to give specific consideration to personality disorder when reviewing the law concerning serious violent sexual offenders, appearing to regard this as the unwelcome intrusion of the DSPD agenda.
In their report the MacLean Committee rejected the idea that the development of a medical protocol, in accordance with the DSPD programme, was appropriate for the treatment of offenders who may attract a diagnosis of personality disorder. In its report the committee

reaffirmed the established Scottish position: namely that for those who commit offences, prison rather than hospital should provide the normal means of disposal. The committee went further by challenging the very assumption that personality disorder was likely to be of any great importance in the commission of serious violent or sexual offences: see Sections 2.32, 7.4 and 10.2.

This contrasts with the position in England, whereby those with a primary diagnosis of personal disorder have not been systematically excluded from the Special Hospitals. The position favoured by the Maclean Committee was therefore directly contrary to that being advocated by the UK Government in pursuit of its DSPD agenda, thereby providing evidence of a divergence of policy between these two jurisdictions.

Social Aetiology and Inclusion - The Acceptance of an Alternative Paradigm?

During the course of this research it emerged that increasing recognition is being given to the social context in which problems of human functioning emerge and of the potential for trauma to impact upon individual growth and development. This would in part appear to reflect the growing influence of psychological approaches, as exemplified in the position statement in response to the launch of DSM 5, published by the Division of Clinical Psychology (2013) of The British Psychological Society.

> "(Trauma is increasingly being seen as a central) organising aspect (of personality disorder)" (R 14: Key Informant - The Scottish Government).

and more specifically to have a:

> "...significant read across to the BPD group" (R 14: Key Informant - The Scottish Government).

The significance of adopting a trauma-based approach to working with those who may attract a diagnosis of personality disorder was also echoed by a broad range of respondents typified by the following comment:

> "I have huge empathy because I think, looking back I've never yet come across somebody with that diagnosis that didn't have sort of terrible trauma" (R: 05 Mental Health Officer).

> "...functioning and well-being in the... more traditional approach of psychotherapy and recovery (represents a key element of the policy and strategy being pursued by the Scottish Government) " (R 14: Key Informant - The Scottish Government).

> "...we've got the generic standards for admission and discharge... but also then the specific care standards in respect of borderline personality disorder, that's the way in which we've sought to bring personality disorder within the wider context of good quality health

care, by identifying it as one of the five alongside schizophrenia and bipolar disorder ...and depression" (R 14: Key Informant).

"(as this group of patients typically presents)...with relationship problems and social problems" (the implication being that they do not fit comfortably within the standard medical model) (R 14: Key Informant - The Scottish Government).

"(this reflects a broader policy attempt to refocus services such that they become more) trauma-sensitive" (R 14: Key Informant - The Scottish Government).

Advocates of the trauma based paradigm argue that recovery should be seen as a reasonable expectation, rather than the exception or near impossibility:

"If skin can heal itself with minimum non-drug support, why can't minds" (Johnson 2010: 4).

It would seem therefore that trauma has been invoked in order to reposition personality disorder, in policy terms at least, so that it sits more comfortably within health care policy. This emphasis upon trauma, in terms of the aetiology of personality disorder, is particularly significant because it represents a distinct alternative perspective to the standard medical model, thereby representing a challenge to the traditional medical paradigm underpinning psychiatric nosology. This alternative approach

has been termed a "neo-medical model" (Johnson 2010):4. The notion of trauma is also inherently more compatible with the notion of recovery (Department of Health and Well-Being 2007) which is a prominent feature of current mental health policy. The apparent shift away from the classical medical model is also reflected within a number of key policy documents:

> "Our approach is based on a social model of health which recognises that our mental state is shaped by our social, economic, physical, and cultural environment, including people's personal strengths and vulnerabilities, their lifestyles and health-related behaviours, and economic, social and environmental factors" (Department of Health and Well-Being 2009: 6).

> "One of the main themes of the standards is the incorporation of a recovery approach. ICPs must capture the ethos and values of recovery and to deliver recovery-orientated services" (NHS Quality Improvement Scotland 2007: 6).

It is noteworthy that within the Mentally Flourishing Scotland policy framework referred to above, the focus is exclusively upon recovery for those who attract a diagnosis of mental illness - there is no consideration whatsoever given to those who may attract a diagnosis of personality disorder. This may go some way to explain why recovery approaches did not emerge as having a significant impact upon practice for those who may attract a diagnosis of personality disorder during the course of this research.

The changing way in which borderline personality disorder in particular is being reconceptualised is evident from a consultation paper concerning the development of an Integrated Care Pathway (ICP) published by North Lanarkshire Council and NHS Lanarkshire in August 2010. This consultation paper is entitled: is 'Borderline Personality Disorder/Complex Trauma'? Citing NICE as an authoritative source this consultation paper makes it clear that the understanding of personality disorder is increasingly being based upon the concept of trauma. Specific prominence is also given to recovery in contrast to the policy at a national level discussed above. This policy perspective owes a good deal to the social as distinct from traditional biomedical approaches to understanding health and well-being. This is consistent with the current influence upon policy of those advocating an emphasis upon the social determinants of health (Marmot 2010).

This repositioning of personality disorder as a response to trauma i.e. a reaction to experiences primarily beyond the control of the individual, may have the effect of reducing the sense in which those who attract this diagnosis are held to be morally culpable for their 'problematic' behaviours. This shift is essential if the policy objective, whether considered desirable or not, of repositioning Borderline Personality Disorder within the medical / healthcare paradigm is to be accomplished.

The Matrix - a Scottish Alternative to NICE

Models of clinical governance in Europe and beyond increasingly reflect the importance of integration underpinned by clinical pathways, of which integrated care pathways are an example. Within England and Wales NICE, a special health authority, has a strategic role in driving clinical practice by evaluating and indicating which treatment modalities should be made available. Policymakers in Scotland have however adopted a different approach; in the case of mental health the chosen method of influencing clinical governance and practice is based upon the Matrix of Psychological Therapies (NHS Education Board for Scotland 2008), otherwise referred to as 'the Matrix' in conjunction with the integrated care pathways for mental health (ICP). Together these form the backbone of policy in respect of clinical governance vis-a-vis mental health in Scotland.

> "... the Matrix of psychological therapies... wasn't like NICE... (rather it was) intended as a communication to health boards" (R 14: Key Informant - The Scottish Government).

> "...we're doing two pieces of work, one of which is on establishing information systems to monitor the application of the Matrix in practice, but also...alongside (that) work on referral pathways so that we can actually set expectations about how people actually choose and select; and that is intended to enable us then to set, in

due course, access time targets" (R 14: Key Informant - The Scottish Government).

The adoption of the Matrix does not therefore mean that the Scottish Government favours a laissez-faire approach to the implementation of its mental health strategy. The extent to which the ICP for mental health can be expected to deliver significant benefits to service users has however been called into question:

"...we probably just see ICPs as another layer of bureaucracy... probably... funding went to other things... it's ...negligible as to whether ICPs... within mental health are going to shape and improve services... it's a kid on if we think that having an ICP is going to open the door to people coming into services, because ICPs don't deal with attitudes" (R 16: Key Informant from a voluntary sector organisation directly involved in the planning of the ICP for mental health).

More specifically focusing upon borderline personality disorder, the majority of the recommendations for the ICP were absorbed within the generic standards. The ICP for borderline personality disorder is introduced as Standard 26 under the heading 'Condition-Specific Care Standards' (p 57). Standard 26 is simply entitled 'Medication' (NHS Quality Improvement Scotland 2007):

"...the integrated care pathway for borderline personality disorder ended up being a tiniest little thing in a sense that it was just... the medication that was all that was left" (R 19: Key Informant and Psychiatrist).

"…if it's already a diagnosis of exclusion then you are only going to make it more exclusive by making the ICP only for one of the Personality Disorders…if you cut it down to just borderline then what about everybody else. If you have a PD diagnosis and obviously I know that a lot more people are diagnosed with borderline than the other ones but equally there is a lot of, it is quite common not to have just one and, you know, there is a lot of crossover" (R 18: Key Informant and Service User).

However:

"...unfortunately borderline personality disorder is the only condition that has an evidence based acute intervention and even that is a bit wobbly, but the others just don't have anything. Not because I don't think that they're treatable, but that people haven't offered...well people haven't done the kind of research that things like integrated care pathways and NICE guidelines blah, blah, blah require. So borderline personality disorder is the only personality disorder, and you've got anti-social personality disorder down South as well, with the NICE guideline, you know, so it really is much more about the academic perspective of having to get the right

> evidence base to be able to write these things up in a kind of authoritative way (R 19: Key Informant and Psychiatrist).

The importance of the Matrix and ICP for mental health emerged as a significant theme during the course of this research: this was not least because the probable significance of this two-pronged strategy for those who may attract a diagnosis of personality disorder is concerned is contested.

The ICP for mental health is underpinned by specific standards namely: The Standards for Integrated Care Pathways for Mental Health (NHSQIS 2007). These standards followed the draft standards published earlier in that same year without any changes being made regarding personality disorder. Both the draft standards and the final standards make reference to borderline personality disorder exclusively rather than personality disorder more generally.

The ICPs for mental health consist of four sets of standards and five specific conditions. The four elements are: Process Standards, Generic Care Standards, Condition-Specific Care Standards and Service Improvement Standards. The five specific conditions are: Bipolar Disorder, Dementia, Schizophrenia, Depression and Borderline Personality Disorder.

The adoption of the ICP approach to the provision of mental health services was a policy response to the perception that:

> "...mental health services sometimes lack coordination, do not deliver evidence-based interventions, do not record outcomes and often do not meet service user assessed needs" (NHS Quality Improvement Scotland 2007: 4).

The standards document makes it clear that in response to these findings NHS QIS published a three year strategic programme of work in 2005 entitled 'Improving the Quality of Mental Health Services', 2005-2008 (NHS Quality Improvement Scotland 2005). This strategic plan recommended the introduction of ICPs to ensure a much better level of coordination and to allow the measurement of:

> "...the extent to which the needs of service users are actually met" (NHS Quality Improvement Scotland 2007: 4).

The agenda of inclusion contained within Delivering for Mental Health (Scottish Executive Health Dept 2006) is consistent with international agreements predicated upon a rights-based approach (World Health Organisation 1986; 2005). This inclusive approach to mental disorder ostensibly provides the basis for the Mental Health (Care and Treatment) (Scotland) Act 2003.

Delivering for Mental Health (Scottish Executive Health Dept 2006) was part of a broader health strategy that saw the publication of Delivering for Health in 2005 (Scottish Executive Health Dept 2005). Delivering for

Health contained a commitment to introducing ICPs including personality disorder:

> "In Delivering for Mental Health we committed to developing standards by the end of 2007 for Integrated Care Pathways (ICPs) for schizophrenia, bi-polar disorder, depression, dementia and personality disorder" (Scottish Executive Health Dept 2006: 8).

Delivering for Mental Health (Scottish Executive Health Dept 2006) contained the phrase "personality disorder":6; rather than the much more restricted form of borderline personality disorder. This is highly significant, not least because of the fundamental role that the ICP governance framework, together with the Matrix for Psychological Therapies is intended to play in steering practice within Scotland.

Clear differences emerged during the course of this research concerning the aspirations and expectations for mechanisms such as the Matrix and ICP to impact upon practice. From the point of view of the Scottish Government, the Matrix and ICP are intended to directly influence practice by making expectations clearer both to clinicians and indirectly service users; furthermore the Matrix and ICP are designed to sit within a broader framework of clinical governance, allowing a degree of central steering to take place through the introduction of targets: this aspect of clinical governance will be discussed subsequently within this chapter. The Key informant from the Scottish Government (R: 14) was clearly of the view that the combination of the Matrix and ICP represented a preferred way

forward in Scotland, as an alternative to the approach adopted in England based upon NICE. The other two key informants, both of whom were involved in the establishment of the ICP for mental health, expressed views that were however much less optimistic regarding the probable significance of the ICP in terms of its impact upon practice.

This tension between aspirations and expectations can be partly understood in terms of a more fundamental tension between meeting the needs of those with severe and /or enduring mental illness and the perceived needs of those who may attract a diagnosis of personality disorder. This tension was specifically acknowledged within 'The Framework for Mental Health Services in Scotland' (Scottish Office and Dept of Health 1997). The tension arises due to the poor fit between personality disorder and the way that mental health services have historically been constituted i.e. Based upon the perceived needs of those who attract a diagnosis of severe and / or enduring mental illness. This framework document provides the conceptual basis for the subsequent Matrix. The policy origins of the framework and by extension the Matrix can however be traced farther back to work undertaken in the mid-1990s by the Scottish Office:

> "The Mental Health Reference Group (MHRG) was set up in 1996 to assist the (then) Scottish Office working party developing the first draft of the Framework" (Mental Health Reference Group 2000):5.

> "During the 1990s, especially in England, a series of incidents such as the Christopher Clunis episode heightened public awareness. For

> some this was taken to an exaggerated extent in considering the risk to the community arising from those with mental health problems who live within it" (Mental Health Reference Group 2000: 7).

Consequently:

> "A central part of the philosophy of the Framework for Mental Health Services in Scotland (1997) was that no patient should be discharged from hospital unless services and accommodation were in place and available" (Mental Health Reference Group 2000: 7).

These comments illustrate that concerns about risk were foundational to the process of reviewing mental health legislation in Scotland in the late 1990s as they were in England.

Why the Focus on Borderline Personality Disorder?

During the course of reviewing the literature in preparation for undertaking the empirical field work at the heart of this thesis, as well as during the fieldwork itself, it became evident that among the variety of diagnostic labels available that borderline personality disorder was receiving notably more recognition:

> "People with borderline personality disorder are not going to fail to come to somebody's attention and when they do come to somebody's attention they will generally cause alarm unless a service is actually used to dealing with them...So I think there's a disappointing lack of interest in other personality disorders... I don't think they're seen as a focus for treatment... they're a group that have generated a great deal of interest research wise as well in contrast with some of the other personality disorders and so there are evidence based treatments as well, and because they come psychiatrists' way and because psychiatrists have drugs to use they also use drugs on them and so drugs companies get very interested in them as well" (R: 17 Psychiatrist).

Consequently:

> "(BPD) has almost become synonymous with personality disorder" (R 17 - Key Informant and Psychiatrist).

Several possible explanations can be identified to help understand why in clinical practice as well as policy in Scotland, BPD and personality disorder have become conflated into a single entity. As highlighted earlier, borderline personality disorder has a more substantial evidence base than can be said for other diagnoses of personality disorder. This may in part be because those with this diagnosis are more likely to seek treatment, (Bateman and Tyrer 2004) than those who are diagnosed with other categories of personality disorder, thereby making it somewhat easier for

an evidence base to be accumulated. Having a treatment seeking orientation is certainly more consistent with the inherent assumptions of the 'sick role' that is central to the medical model (Rush 2004). Alternatively BPD may have become synonymous with personality disorder because its associated symptoms are believed to be more susceptible to pharmacological interventions: borderline personality disorder has featured quite extensively within drug trials (Tyrer and Bateman 2004).

Pharmacological interventions have become the dominant modality within modern psychiatry (Nadesan 2008). This to some extent reflects a mutual interest between psychiatrists in terms of increasing and reinforcing their status within the medical profession and the financial interests of pharmaceutical companies (Carlat 2010). These potential conflicts of interest are well illustrated by the scandal involving GlaxoSmithKline resulting in a fine of $3 billion in 2012. This pharmaceutical company was fined for withholding data concerning the safety of its products and providing unlawful financial incentives to doctors as part of a strategy known as 'off-label marketing' (Reuters 2012). It is noteworthy that despite the acknowledged benefits of approaches such as cognitive behavioural treatment for some service users who may attract a diagnosis of personality disorder (Working Group on Services for People with Personality Disorder 2005) that the integrated care pathway referred to above focuses exclusively upon medication rather than other forms of intervention. This reflects the prevalence of a biomedical approach to the

treatment of mental health problems that allows pharmaceutical companies to significantly influence clinical norms (Pilgrim 2012).

The Continued Exclusion of Antisocial Personality Disorder

In response to published data (Thomson 2005) suggesting that up to 80% of prisoners within Scotland may meet the diagnostic criteria for this diagnosis, one particularly respondent with a key role in implementing government policy noted that:

> "I don't think that's the case at all, I don't think I've seen anything which suggests antisocial personality disorder. (The) diagnosis that we see within the prison population would probably be borderline personality disorder, and so 80% isn't a figure that I'd recognise" (R 14: Key Informant – The Scottish Government).

This contrasted with the view of another respondent who noted that:

> "...obviously the percentage of prisoners with antisocial personality disorders is very high" (R 02: Psychiatrist).

The potential implications of a shift from a corrections to healthcare paradigm for those who commit offences and also have been given a diagnosis of antisocial personality disorder are far reaching:

> "We would see some relocation (*of the prison population*) from the justice system into the health care system and probably reasonably quickly, demands for further increases and extension of that provision" (R 14: Key Informant – The Scottish Government).

Consequently:

> "(Those who attract a diagnosis of dissocial/antisocial personality disorder are)...better handled within the justice system" (R 14: Key Informant - The Scottish Government.

The view taken by policymakers in Scotland was therefore that rather than being brought within the health paradigm that those who attract a diagnosis of antisocial personality disorder, should be kept firmly within the justice / corrections paradigm. It became clear during the course of this research that part of the reluctance to include a broader definition of personality disorder within the Matrix, including antisocial personality disorder, was that of the potential consequences of increased demands upon health services.

> "I think they probably don't have a place within psychiatry, you know within medicine and they are probably best dealt with legally (R 02: Psychiatrist).

This is an opinion which can be contrasted with:

> "(I) don't think there's any reason why we shouldn't be seeing antisocial personality disorder" (R 19: Key Informant/Psychiatrist).

> "(however in establishing the personality disorder network)...we did kind of separate ourselves off from the forensic aspect... we didn't want people to think that personality disorder meant forensic" (R 19: Key Informant/Psychiatrist).

As can be seen from the above comments a lack of consensus among respondents regarding the most appropriate response to the needs of those with antisocial personality disorder emerged during this research. Even among those therefore who adopt a more inclusive approach towards antisocial personality disorder, a concern was evident for the need to maintain a degree of distance between those who attract this diagnosis and other forms of personality disorder. This led to a clear decision to exclude those who fall within the so-called forensic sphere from the agenda of the Scottish Personality Disorder Network.

Somewhat contrary to the view expressed by the key Government informant (R:14), the MacLean Committee accepted research findings that the prevalence rate of antisocial personality disorder amongst sentenced male prisoners in Scotland was high at approximately 50% (MacLean 2000: para 10.17). This was somewhat less than other estimates that put the figure as high as 80% (Thomson 2005). A discussion document published by the forensic network contains a very

clear statement concerning the policy of exclusion within Scotland, summarising it as one of:

> "Do not admit individuals with a primary diagnosis of personality disorder to forensic psychiatric units" (Thomson 2005).

This same document argues for an end to antisocial personality disorder as a diagnosis of exclusion in Scotland:

> "Personality Disorder should not be a diagnosis of exclusion from Forensic Mental Health Services. Services for people with personality disorder should be provided given the frequency with which they are found in the criminal justice and mental health systems in Scotland" (Thomson 2005).

HEAT Targets and Personality Disorder - a Diagnosis Too Hot to Handle?

Delivering for Mental Health (Scottish Executive Health Department 2006) contained a number of commitments, one of which namely commitment 6, provided for the basis of a number of HEAT targets that were intended to direct policy and practice at a local level.

> "(HEAT targets) dictate the agenda" (R 20: Key Informant - in a pivotal strategic position within the NHS in the West of Scotland).

This confirms the importance that HEAT targets are intended to have as an accompaniment to the Matrix and driver behind the ICP for mental health and that they have become operationalised in strategic planning. From this it necessarily follows that the precise details of the relevant HEAT target are most important.

When respondents were asked what procedures or guidance had been issued to clarify how those who may attract a diagnosis of personality disorder should be accommodated within service provision, without exception, no respondent was able to identify any specific procedures or guidance. The following represents the views typically expressed by respondents:

> "No guidance has been issued for working with those with personality disorder - none at all" (R: 26 Mental Health Officer)

Delivering for Mental Health contained three specific HEAT targets. Commitment 6 within Delivering for Mental Health is specifically linked to these three HEAT targets (Scottish Executive Health Department 2006: 20). These HEAT targets were clearly intended to be fairly generic:

> "Target 1: Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10
> Target 2: Reduce suicides in Scotland by 20% by 2013
> Target 3: Reduce the number of readmissions (within 1 year) for those that have had a hospital admission for over seven days, by

> 10% by the end of December 2009" (NHS Quality Improvement Scotland 2007: 5).

The original targets were subsequently revised at the end of 2007 and a fourth, this time diagnosis specific target concerning dementia was added (NHS Quality Improvement Scotland 2008). A specific HEAT target for the waiting time for psychological therapy was approved by the Scottish Government in November 2010 to be included as a HEAT target from April 2011 onwards: the waiting time target being a period of 18 weeks from initial referral to the commencement of treatment (Information and Services Division NHS Scotland 2011). The published commitment was however rather narrow in its focus:

> "Our intention is to promote timely delivery of evidence-based psychological therapies to treat mental illness" (Information and Services Division NHS Scotland 2011).

The fundamental issue with the adoption of this HEAT target as far as those with an interest in personality disorder are concerned, is that it focuses explicitly upon mental illness and omits any reference to personality disorders whatsoever.

Uncertainty regarding the efficacy of available treatments is unlikely to have provided the basis for this decision given the acknowledgement of specific psychological interventions for borderline personality disorder within the Matrix. Furthermore the policy document accompanying this

HEAT target asserts that uncertainty regarding treatment efficacy should not preclude interventions being undertaken. The point is made that clinicians must be free to undertake therapeutic interventions based on the needs of patients. The imperative to intervene is regarded as overriding the absence of an established treatment methodology: the assumption is rather that the Matrix will be updated as clinical experience develops further (Information and Services Division NHS Scotland 2011).

The strategic decision to omit personality disorder from this key target becomes all the more obvious when the details of those whom the target is intended to apply to are indicated:

> "where the therapy is delivered to individuals or groups on a face-to-face basis, by staff trained to recognised standards, operating under appropriate supervision, in dedicated/ focused sessions
> to all ages (including CAMHS services);
> in inpatient as well as community settings;
> in physical health settings where there is associated mental illness such as depression or anxiety e.g. chronic pain and cancer;
> for substance misuse where there is associated mental illness;
> for learning disabilities where there is associated mental illness"
> (Information and Services Division NHS Scotland 2011).

Substance misuse, learning disabilities and even physical pain and diseases such as cancer are included within the HEAT target for access to psychological treatment, under the broad term of mental illness. The

omission of personality disorder is therefore particularly notable within this otherwise very broad and flexible approach to how this HEAT target should be interpreted.

Another key policy document namely: Equally Well (The Scottish Government 2008) also notably omits any reference to personality disorder when making reference to the Scottish Government's current agenda:

> "The Government's Delivering for Mental Health Programme is improving care and treatment for people. It covers not only those with severe and enduring illnesses such as schizophrenia, bi-polar disorder and dementia, but also those with a wider range of conditions such as depression, anxiety and stress":37.

The Scottish Government (Department of Health and Well-Being 2007) published an implementation plan to accompany 'Towards a Mentally Flourishing Scotland' in October 2007. The implementation plan was entitled 'The Future of Mental Health Improvement in Scotland 2008-11'. In keeping with other policy documents referred to above, this document places the emphasis explicitly upon mental illness and admits any reference to personality disorders. The vision outlined within this particular document is intended to:

> "...prevent, treat and care for mental illness and improve the quality of life for people living with mental illness" (Department of Health and Well-Being 2007: 2).

One possible explanation for the omission of personality disorder from the mental health policy framework in Scotland might be that of the political challenge of justifying expenditure on a group of service users who are characteristically unproductive (Pilgrim 2012). Service users who attract a diagnosis of personality disorder are perhaps the most likely to be designated as least susceptible to being behaviourally activated to participate productively in the labour market. Given the greater emphasis that has been placed upon personality disorder by the UK Government, albeit substantially driven by an agenda based on risk, it is perhaps not surprising that personality disorder has not been excluded from the equivalent policy in England intended to increase access to psychological therapies (Department of Health 2012), this however makes the exclusion of this group of service users from key aspects of policy in Scotland all the more stark in contrast.

Conclusion

Notwithstanding the arguments advanced in favour of inclusion by those who believe that this is the most effective means of promoting the rights of those who attract a diagnosis of personality disorder, those who do attract this diagnosis continue to occupy an ambivalent position within law and policy in Scotland.

The explicit inclusion of personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003, follows from the amendment to the law introduced in the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. This had the effect of making the inclusion of personality disorder explicit in Scottish mental health legislation for the first time. The decision to retain the explicit inclusion of personality disorder in the 2003 Act does not merely follow in a sequential sense; rather it became clear during the course of this research that the continued explicit inclusion of personality disorder followed as a practical political necessity. Once again, notwithstanding the potential merits of explicitly including personality disorder in Scottish law in terms of increasing access to services, the original decision to explicitly include this form of diagnosis was largely a response to tabloid driven anxieties, resulting in the decision by the Scottish Executive to pursue the enactment of emergency legislation. Had it not been for this emergency legislation then the previously established position of the innominate inclusion of personality disorder in Scots law would in all likelihood have been maintained. The adversarial approach adopted by the UK

Government towards the perceived failure of psychiatrists in particular to grasp the nettle and accept their responsibility to work with those who attract a diagnosis of personality disorder, particularly dissocial / antisocial personality disorder, was not echoed in Scotland. Rather in Scotland a greater consensus was evident in the desire to maintain the policy of not admitting those with a primary diagnosis of personality disorder to forensic settings, reflecting the position that became established in Scotland in the mid-1970s. Due to its explicit rejection of the DSPD agenda being pursued by the UK Government, the MacLean Committee proved instrumental in allowing the established Scottish position to be largely maintained in regard to the 'do not admit' policy.

The Millan Committee took their lead from the MacLean Committee with regard to the DSPD agenda. During the course of this research it became clear that the concept of trauma has been used to make the inclusion of personality disorder, in the limited form of borderline personality disorder at least, more palatable to those who question its legitimacy within the biomedical paradigm. A trauma-based approach is also more consistent with the ethos of recovery and that is a key aspect of current Government policy. Despite the initial broad-based inclusion of those who might attract a diagnosis of personality disorder, a process of narrowing is evident resulting in a much more limited focus upon the inclusion of those who attract a diagnosis of borderline personality. Even this more limited focus disappears completely within some key aspects of policy, most notably the HEAT target for waiting times for psychological treatment. The Millan Committee acknowledged a range of opinions regarding the merits of

explicitly maintaining the inclusion of personality disorder within the law in Scotland. Despite the current emphasis upon a more rights-based approach to mental health law, the explicit inclusion of personality disorder within the emergency legislation of 1999 and its subsequent retention within the Mental Health (Care and Treatment) (Scotland) Act 2003, was not primarily based on an acknowledgement of the legitimate needs and rights of those who attract a diagnosis of personality disorder. The inclusion of personality disorder owed more to earthy considerations such as the political imperative for the Scottish Executive, and Scottish Parliament more broadly to reinforce its legitimacy. To this end it was necessary for the Parliament to be seen to be able to provide an effective regulatory framework to maintain order. To this extent the decision to explicitly include personality disorder within mental health legislation in Scotland does reflect the broader imperatives of an approach to control the regulation that reflects neoliberal governmental imperatives (Pilgrim 2012).

To date the decision to explicitly include personality disorder within mental health legislation does not appear to have significantly impacted on the ability of those who attract a diagnosis of personality disorder to access appropriate services in a timely manner. The extent to which this state of affairs is likely to change will depend on a substantial extent upon the efforts of organisations such as the Scottish Personality Disorder Network who continue to champion the rights of those who attract a diagnosis of personality disorder to meaningful inclusion within the spectrum of service provision. This network is even more important given

the absence of any other obvious champions to assert the rights of this group of service users. The assumption of entitlement that might be presumed by many to follow from the explicit inclusion of personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003 is likely to remain an unfulfilled hope. This is not least because entitlement without the provision of services cannot materially impact the ability of those who attract a diagnosis of personality disorder to successfully access appropriate services. As things currently stand therefore those who attract a diagnosis of personality disorder in Scotland are likely to continue to experience significant levels of marginalisation and exclusion.

Chapter 9:

Final Conclusions

The purpose of this research has been to explore five key questions that are of fundamental importance to the well-being of those who attract a diagnosis of personality disorder in Scotland. These were: 1) in what ways does the inclusion of personality disorder within mental health law in Scotland reflect an acknowledgement of the legitimate needs and rights of service users?; 2) how does the inclusion of personality disorder within mental health law fit into a broader range of strategies of control and regulation characteristic of an advanced liberal democracy?; 3) how has the inclusion of personality disorder influenced the way in which those who attract a diagnosis of personality disorder are perceived by front-line workers?; 4)in what ways, if any, have front-line workers changed their response to those who attract a diagnosis of personality disorder as a consequence of current legislation?; and 5) how has current legislation influenced the availability of, and access to, services for those who attract a diagnosis of personality disorder?

The inclusion of personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003 reflects two very different agendas. During the course of this research clear evidence emerged of the significance of the political imperative of the newly devolved Government in Scotland to demonstrate that it could fulfil one of its most basic duties, namely that of maintaining order by being seen to effectively manage and limit the potential for disorder. A potential crisis of legitimacy for the

newly established parliament was triggered by the legal ruling requiring the release from detention of Noel Ruddle, this resulted in emergency legislation in the form of the Mental Health (Public Safety and Appeals) (Scotland) Act (1999), often referred to as 'Ruddle's law'. The potential for a political crisis in Scotland was increased due to the support in the tabloid press for the punitive policies being pursued at that time by the UK Government. The second agenda was that of a campaign that championed the rights of those who attract a diagnosis of personality disorder to be included within mental health legislation, in order that their needs could be more readily acknowledged and services provided. In England this was most clearly expressed in the strategy document Personality Disorder No Longer a Diagnosis of Exclusion (National Institute for Mental Health in England 2003). While in Scotland there was no equivalent policy document, the agenda of inclusion was reflected in the establishment of the Scottish Personality Disorder Network. Two very different agendas can therefore be identified that underpin the explicit inclusion of personality disorder within mental health law in Scotland. The underpinning logic of these two agendas is however very different indeed. These differences create tensions and contradictions that explain why despite the explicit inclusion of personality disorder within legislation, the subsequent policy framework largely excluded or at best marginalised those who may attract a diagnosis of personality disorder.

During the course of this research some evidence emerged that those who attract a diagnosis of personality disorder are somewhat less likely to be perceived as making an illegitimate claim upon services when they

express their needs. This change in perception however is far from uniform, meaning that for service users the response they receive continues to be something of a lottery. The perception of those who attract a diagnosis of personality disorder also continues to be significantly influenced by the specific form of diagnosis or combination of diagnoses that are attached to any given service user. Among the various diagnoses of personality disorder that can be made, borderline personality disorder has received by far the most attention in policy documents and academic publications. One consequence of this is that service users who may attract this particular form of diagnosis are somewhat less likely to be automatically filtered out and therefore excluded from services. Those who attract a primary diagnosis of other varieties of personality disorder are however likely to continue to be perceived fairly negatively and face a significantly greater risk of being excluded from service provision.

To date the impact of the inclusion of personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003, has at most been to offer encouragement to those seeking to drive forward cultural change by promoting the acceptance and meaningful inclusion of those who attract a diagnosis of personality disorder within service provision.

The diagnosis of personality disorder continues to be and is likely to remain deeply contested in almost every respect. Those who attract a diagnosis of personality disorder in Scotland, despite the efforts of the Scottish Personality Disorder Network, are likely to continue to experience significant obstacles in accessing appropriate services in a timely manner.

These obstacles stem from difficulties following from service structures and the prerequisite necessity for those seeking services to be service ready. Other impediments originate from processes of bifurcation and filtration; these processes frequently result in those who have attracted a diagnosis of personality disorder, or are likely to do so, being screened out and therefore effectively being denied access to services. The majority of services continue to place an exclusive emphasis upon working with those with whom they have traditionally been concerned, namely those who fall within the diagnostic circumference of severe and enduring mental illness.

The explicit inclusion of personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003, has not been fully reflected in subsequent policy developments and frameworks that play a crucial role in steering policy and practice at a local level. Those who attract a diagnosis of personality disorder are likely to continue to occupy an ambivalent and uncertain position that can be characterised as somewhat of a 'twilight zone'. In this case the zone is bounded by perceptions of legitimacy and illegitimacy: the boundary encompassing legitimacy is still predominantly defined in terms of a traditional medical emphasis favouring those who attract a diagnosis of a severe and enduring mental illness: those who attract diagnoses that fall outwith this boundary however continue to be perceived with varying degrees of illegitimacy and are therefore deemed to be less eligible for services. A further distinction between those who are deemed to be making a legitimate and illegitimate claims upon services concerns the maintenance of the established

Scottish position regarding those who attract a diagnosis of dissocial / antisocial personality disorder. This is despite the fact that the legislation makes no distinctions whatsoever in terms of the different forms that a diagnosis of personality disorder may take, instead simply referring to personality disorder. The narrowing of focus to that of borderline personality disorder also emerged as a key development during the course of this research. As discussed in the preceding analysis this process has moved beyond one of narrowing, so that within key policy developments and frameworks reference to personality disorder is simply omitted altogether.

It emerged during the course of this research that the perception of those who attract a diagnosis of personality disorder among front-line workers, ranges from one of broad acceptance to considerable scepticism and reticence to embrace them within service provision. In practical terms it emerged that there was some evidence of limited changes in the response at a local level to those who attract a diagnosis of personality disorder; more fundamentally however, those who attract this diagnosis are still subject to various processes of screening and filtration that significantly reduce the opportunities for them to access appropriate services in a timely manner. The overall impact on the availability of services stemming from the decision to specifically include personality disorder within the Mental Health (Care and Treatment) (Scotland) Act 2003, consequently appears to be negligible reflecting the very real limits of legalism (Pilgrim 2012). For the foreseeable future it is unlikely therefore that those who attract a diagnosis of personality disorder in Scotland are

going to be able to access appropriate services in a timely manner on a consistent basis.

The original decision to amend the Mental Health (Scotland) Act 1984, to explicitly include personality disorder within mental health law in Scotland was rooted in a panicked political reaction. This reaction was based upon fears that the legitimacy of the newly established Parliament in Scotland might be called into question if decisive action was not demonstrably taken. The political response to these anxieties was that of the decision to enact the emergency legislation of 1999 referred to above. This interpretation is consistent with the findings contained within Millan Report (2001) and the comments of a Key Informant from that same committee, both of which have been explored within this thesis. This interpretation is also consistent with the particular problems of maintaining political legitimacy within Parliamentary democracies (Offe 1976; Pilgrim 2012).

The de facto exclusion of many of those who may attract a diagnosis of personality disorder in Scotland has therefore been maintained by three key impediments. Namely a policy framework that effectively entrenches the marginalised position of this group of service users; residual ambivalence towards the legitimacy of the diagnosis of personality disorder itself, and the legitimacy of the claims made upon services by those who have attracted this form of diagnosis; finally insufficient and inadequately focused resources for which networks, no matter how sincere their members, cannot provide a sufficient substitute for services.

The explicit inclusion of personality disorder within mental health law in Scotland was essentially coercive, predicated on the assumption that a dangerous legal loophole needed to be urgently closed. Although this rationale is less obvious in the Mental Health (Care and Treatment) (Scotland) Act 2003, the so called 'public safety test' introduced in the Mental Health (Public Safety and Appearance) (Scotland) Act 1999 has not been repealed. The political imperative for the explicit inclusion of personality disorder is therefore consistent with the argument that:

> "…the State differentially focuses on the coercive management of social problems under the guise of the paternalistic care of individual pathology" (Pilgrim 2012:1079).

The explicit inclusion of personality disorder within legislation in Scotland therefore, on the one hand closes the so-called loophole based on the treatability criterion, thereby allowing those who may attract a diagnosis of personality disorder to be detained when they might otherwise have to be released, while at the same time doing little to genuinely promote the inclusion of a much broader range of people who may attract a diagnosis of one form of personality disorder or another. The absence of follow-through in terms of a policy framework to promote inclusion may also reflect the perception that those who may attract this form of diagnosis have less economic utility because they are less amenable to being behaviourally reactivated and participating in the labour market (Pilgrim 2012).

This thesis represents an example of how the post-empiricist model proposed by Derek Layder can be effectively used to investigate complex issues that combine law, policy and practice. This thesis provides an example of how a comprehensive historical analysis of law, policy and practice provide a necessary context in which to interpret findings from the empirical research into current practice and the impact of law and policy. This study also provides an example of how adopting a different perspective, in this case that of service readiness, can provide a significantly different vantage point from which to view and interpret how services respond to the needs of potential service users. In this case the concept of service readiness was used as a direct alternative to the more commonly used concept of hard to reach groups. This relatively new approach to understanding how and why marginalised groups become excluded from service provision and how this exclusion is maintained, offers the potential for the development of a radically different approach to understanding how services should be commissioned, designed and then ultimately offered.

This thesis has a number of specific implications for the development of policy and practice. With specific regard to the policy framework, then this in effect reinforced the traditional position and status of those who attract a diagnosis of personality disorder as a marginalised group. The clearest example of this concerns the omission from those who attract a diagnosis of personality disorder from the HEAT targets. These targets are specifically intended to drive the way in which services are commissioned, organised, delivered and against which the performance of service

providers are benchmarked. Those who attract a diagnosis of personality disorder have a fundamental human right to have their needs acknowledged and appropriate services provided; they should not continue to be side-lined within policy as a group who are perceived as too problematic to embrace. With specific regard to practice, then the 'lottery effect' created by how clinicians use their discretion to determine how narrowly the concept of treatment should be defined in practice should be specifically challenged. The processes of filtration that emerged during the course of this research based on the criteria of nuisance and risk should also be specifically challenged. During the course of this research the unintended consequences of the more rigorous approach underpinning the use of compulsory treatment and the role of the tribunal system emerged as of particular significance. The safeguards built into the tribunal system are of themselves to be welcomed; however the unintended consequence of marginalising informal patients should be addressed. As envisaged in the Millan Committee report, those who attract a diagnosis of personality disorder are far more likely to fall into the informal rather than formal category and are therefore particularly vulnerable to this particular unintended consequence. Practice takes place within a context framed by law, policy and the structure of services themselves. It became clear during the course of this research that changes to the law in and of itself have relatively little effect upon practice, and therefore the experience of those who are likely to attract a diagnosis of personality disorder. In addition to addressing the current deficiencies described above within the policy framework, it is necessary for services to be redesigned around the needs of potential service users

rather than the administrative requirements of providers. Much has been said and written in recent years about the importance of providing needs-led services: the reality however is that the current way in which services are designed and configured is very far indeed from this. Ultimately it is important to recall why all of this matters: the reason is no less important than the fact that human suffering and misery should be acknowledged and addressed, rather than side-lined simply because it is 'packaged' within a particular diagnostic category.

Limitations of Thesis

This thesis and the analysis that it contains necessarily provide a window into developments within law, policy and practice. The findings are likely to be generalisable to a substantial degree because the policy framework in particular embraces Scotland as a whole, rather than merely being of relevance to the West of Scotland in particular. It should be noted however that the precise ways that policy is implemented on the ground and practice decisions are taken, may to some extent vary on a regional basis. As discussed within this thesis it was not possible to include a substantial number of service users within this study as had been originally intended; further research will therefore be required to ensure that the voices and experiences of service users are brought into and allowed to influence the on-going debate regarding how the needs of those who attract a diagnosis of personality disorder should be catered for within service provision.

Areas for Further Investigation and Final Remarks

Despite its prominence within the broader policy framework encompassing mental health in Scotland, the use of the recovery model did not emerge as a significant theme within this research. The extent to which recovery approaches are being applied to those who may attract a diagnosis of personality disorder therefore requires further investigation. The extent to which the predominant focus upon borderline personality disorder has the effect of screening out those who may attract other varieties of label within the diagnostic suite of personality disorder also requires monitoring and evaluation. Given that the primary focus of social work concerns that of working with the vulnerable and marginalised, it is perhaps surprising that a more clearly defined role for social workers in respect of those who attract a diagnosis of personality disorder was not evidenced during the course of this research. The process of integrating health and social care, or rather social care into health suggests that social workers will need to redouble their efforts to maintain clarity regarding their distinctive role and purpose within increasingly integrated multi-professional teams. The potential contribution that social work as a discipline can make to improving the quality of life for those who may attract a diagnosis of personality disorder is considerable, not least in ensuring that their voices are heard and needs acknowledged. The extent to which social workers can effectively utilise a recovery approach in working with this group of service users in pursuit of these objectives requires further research. This will include finding ways to move beyond the fairly prescribed role of mental health officers within current legislation.

Finally, it is clear from this research that for many of those who attract a diagnosis of personality disorder in Scotland that this is likely to prove to be an on-going obstacle to accessing services and having their needs met in an appropriate and timely manner. Those who attract a diagnosis of personality disorder are likely to continue to occupy an ambivalent and uncertain position, based on the at best partial recognition of the legitimacy of their needs and entitlement to services. Those service users who attract a diagnosis of personality disorder are therefore likely to remain in the twilight zone of mental health practice and service provision: consequently there is reason to believe that those who attract this diagnosis, of whatever form, are likely to continue to experience the "harshly real effects" (p 323) of exclusion (Foucault 2003). As discussed earlier within this thesis the Mental Health (Care and Treatment) Act (Scotland) 2003 has been widely acknowledged as a progressive piece of legislation. For the majority of those who are given a diagnosis of personality disorder in Scotland however, the warning sounded by Stalker (2003) is all too likely to be the reality that they most often experience; namely that they will remain isolated and invisible if they are deemed to be 'low risk' and subject to segregation and exclusionary practices where they are deemed to be other than low risk. This distinction is likely to become even more pronounced for those service users who fall within the forensic sphere. This is perhaps not so much a case of champagne and white cider (Atkinson, Lorgelly et al. 2007) but rather white cider and undiluted bitter lemon!

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Appendices

Appendix 1: Spreadsheet containing historical timeline

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
1809						Pinel describes *mania without delirium* (manie sans delire)
1835						Pritchard describes Moral Insanity
1844					H. M Advocate v Gibson: the concept of moral insanity was rejected as a basis for the insanity defence.	
1844					Her Majesty's Advocate v Gibson: this case resulted in the rejection of vanity as a basis for the defence within Scots law.	
1846		Criminal Lunatics Department established at Perth Prison. This was the first specifically dedicated facility within Scotland for forensic psychiatric patients.				

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
1857						Morel's concept of Degenerative and Pathological deviations from normality, which was said to be causally responsible for mental illness. This idea draws upon the French theory of degeneration. Which greatly in Lombroso and his concept of the born criminal (1867).
1867					Her Majesty's Advocate v Dingwall: this case introduced the concept of into Scots law.	
1889						Koch first used the term psychopathic when he described psychopathic inferiority
1893					Her Majesty's Advocate v Smith: this case resulted in a ruling that for diminished responsibility to be found, they had to be a physiological as distinct from merely mental cause.	
1896						Kraepelin described the concept of Psychopathic States, influenced by the French notion of biological degeneration, which proved to be significantly influential others including Henderson

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
1902					Her Majesty's Advocate v Aitken: the court ruled that brain disease have to be demonstrated in order for a finding of diminished responsibility to be made.	
1908			Royal Commission on the Care and Control of the Feeble-Minded, 1904-1908, Radnor Committee. This provided the foundation for the legislation introduced in 1913 regarding moral imbecility. (Walker and McCabe, 1973), quote this particular commission as stating that it would be "scientifically incorrect" to include a distinctive category for the morally insane within mental health legislation. This commission provided the basis for the introduction of parallel legislation in Scotland and England/Wales.			
1908				Crime Prevention Act		Introduced the concept of preventive detention
1913				Mental Deficiency and Lunacy (Scotland) Act. Moral Imbecile was introduced as a category of mental deficiency. The definition approximated the concept of personality disorder.		
1913					Her Majesty's Advocate v Higgins: Lord Johnston	

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
					rejected the principles of the Dingwall case altogether, arguing that partial responsibility was an illogical concept.	
1913				Mental Deficiency Act (England/Wales)		
1923						Kurt Sncheider differentiated between 10 different forms of psychopathic personality. He provided an important definition of psychopathic personalities as those abnormal personalities whose from their abnormality or whose abnormality".
1923					Her Majesty's Advocate v Savage: this proved to be the most significant case subsequent to Dingwall in there could be term **diminished responsibility** was actually introduced, the directions of Lord Alness had provided a basis for more than legal practice.	
1926			Report of the Departmental Committee on Sexual Offences against Children and Young Persons in Scotland (Scottish Office). This report lamented the underuse of s9 of the 1913			

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
			Act, which the committee believed would allow for the segregation of defective sexual offenders which would facilitate treatment and result in a reduction in recidivism.			
1927				Mental Deficiency Act		
1928			Protection and Training (Scottish Office). This report on juvenile delinquency, recommended that the definition of the moral imbecile be immediately amended, this did not happen within Scotland but did so in England in the 1927 Act.			
1932	May		Report of the Departmental Committee on Persistent Offenders, Home Office.			Highlighted that preventive detention had fallen into disuse in England and to an even greater extent within Scotland.
1939		Psychopathic States published by Sir David Henderson.				
1940				Mental Deficiency (Scotland) Act 1940. This legislation contained the category moral defective of as a replacement of the previous concept of moral imbecility. The intention had apparently been to provide a basis for hospitalising those whose antisocial behaviour was believed to have psychological		

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
				origins. This legislation reclassified the moral imbecile within the term moral defective which itself was a subcategory of mental deficiency. This change had alyesy been made with the Mental Deficiency Act 1927 applicable to England/Wales		
1941						Cleckley use the term "convincing mask of sanity" to describe psychopaths, he also provided 16 different criteria for the diagnosis of psychopathy based upon personality trait theory.
1946					Carraher v Her Majesty's Advocate: Lord Normand ruled that psychopathy to act as a basis for a finding of diminished responsibility as this would have a producing the severity of disposals in the worst offenders. He also argued that the evidence presented to him had simply been descriptive of a typical criminal.	
1946			The Russell Committee (Department of Health for Scotland), strongly influenced by Henderson's concept of psychopathic states: The			

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
			Report of the Committee included a recommendation that the category of moral imbecile should be removed from Scots law can be replaced by legislation for "unstable erratic behaviour types".			
1953			Royal Commission on Capital Punishment (1949-1953), Chaiyes by Sir Arthur Gowers. This commission apparently concluded that the concept of psychopathic States based on the work of Henderson was legitimate but that there was a lack of agreement among psychiatrists about what it meant which was deeply problematic.			
1957				Homicide Act 1957: this applied to Scotland as well as England and the concept of diminished responsibility with and effectively introduced that for the first time into English and Welsh law.		
1957			The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission 1954-57). Recommended the inclusion of psychopathy within the definition of mental illness, and form the basis of the Into			

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
			the Health Act 1959 - England and Wales.			
1958			Dunlop Committee (Department of Health for Scotland), consideyes whether or not the proposals of the Percy Commission should be adopted in Scotland and concluded that they should not; one of the most substantive reasons for the rejection of his proposals was the lack of definition will clarity regarding the concepts involved.this represented a significant point of departure, at least superficially, between Scotland and England/Wales. The Scottish 1960 Act did include the psychopathic group, however only within the grounds for detention and not by name. The English/Welsh legislation explicitly acknowledged the psychopathic group as a distinctive category.			
1960					R v Byrne Court of Appeal. The court gave a wide interpretation to diminished responsibility which had the effect of including personality disorder within this defence, within jurisdictions of England and Wales.	

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
1960				Mental Health (Scotland) Act. This act mirroyes the 1959 Act for England and Wales by including although not naming category of psychopathy. Mental health law in Scotland had remained largely unchanged since 1913 prior to the 1960 Act, despite the 1940 Act.		
1960			Parliamentary Debates (1960) Mental Health (Scotland) Bill, Scottish Standing Committee, House of Commons Official Reports. HMSO. Eighth to Tenth Sittings, p364-452. The report of this committee is said to clearly indicate the intention to mirror the English and Welsh legislation and the inclusion of psychopathy. Consider the comments given in evidence by the Solicitor General.			
1969			Harper Report: Forensic Psychiatry, Report of a Subcommittee of the Standing Medical Advisory Committee. Scottish Home and Health Department, Edinburgh, HMSO			
1975			Crime and the Prevention of Crime: a Memorandum by the Scottish Council on Crime			
1975			Butler Report, Home Office			

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
			and Department of Health and Social Security, Report of the Committee on Mentally Abnormal Offenders, Cmnd 6244. This report is said to have recommended the inclusion of a treatability criterion, which influenced the formulation of the Scottish 1984 Act.			
1976		Escape and murders at Carstairs 1976. Two patients escaped from Carstairs, a diagnosis of personality disorder. It made they murdeyes three people, a nurse pati police officer. This event is distinct from other homicides which have occuryes within some special hospitals, during an escape attempt.				
1977			Scottish Home and Health Department (1977) State Hospital, Carstairs: Report of Public Local Inquiry into Circumstances Surrounding the Escape of Two Patients on 30 November 1976 and into Security and Other Arrangements at the Hospital. The report alleged that expert evidence this is from the BMA came out against detain dangerous psychopaths within			

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
			hospital settings.			
1983				Mental Health Act, this continues with the conclusion of a distinctive psychopathic category		
1984				Mental Health Act (Scotland).this legislation continued with another label psychopathic group I.e. innominate.		
1990	June 5, 1990				Connelly v Her Majesty's Advocate. This case is important because it was subject to contestation in the subsequent appeal made by Galbraith regarding the scope of diminished responsibility. Lord Caplan specifically directed the jury that they could not allow the presence of personality disorder to be regarded as providing a basis for a finding of diminished responsibility. Rather for a finding of diminished responsibility it would be necessary for the jury to be convinced that the accused was suffering from mental illness or a degree of mental impairment bordering insanity.	
1993	1st January	Ben Silcock, enteyes the lion's den at London zoo.				

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
1994					Williamson v Her Majesty's Advocate. This case heard under appeal confirms that personality disorder should be excluded from the criteria for a finding of diminished responsibility.	
1997	Jul, 16	Michael Stone arrested for murder of Megan Russell and Megan Russell and attempted murder of Josie Russell.				
1997	Summer	The new pre-devolution Government established a joint ministerial working group drawn from the Home Office and Health with a remit of considering the need for legislative reform dangerous severe personality disorder.				
1997	September		Framework for Mental Health Services in Scotland (see document by Joint Improvement Team, August 2005			
1998	October	Establishment of the Richardson Committee				
1998	October				Michael Stone sentenced to life imprisonment. He was found to be suffering from a personality disorder are not mentally ill etc. This conviction was quashed in February2001.	
1998					Hutchinson Reid verses Secretary of State for Scotland, House Of Lords	

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
1999	January		Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland. NHS MEL 1999(5) Health Department, The Scottish Office			This "provides the basis for forensic mental health services in Scotland" from The Forensic Network, July 2007 PowerPoint second slide
1999	July		Managing Dangerous People with Severe Personality Disorder - proposals for policy development, Department f Health and Home Office. Consultation Document.			
1999	August		Research Note Mentally Disordered Offenders in Scotland, published by The Information Centre of the Scottish Parliament (99/34)			Specifically highlights personality disorder as a problem to be addressed particularly concerning the need for further legal clarification
1999	November		Richardson Committee Report:published alongside the Green Paper (publication represents sabotage?).			
1999	March	Establishment of the Maclean committee by the UK government.				
1999	November	Reform of the Mental Health Act 1983: Green Paper				
1999			Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital, chaiyes by Peter Fallon QC			This contains some very interesting information relating to concept formation in the history of personality disorder.
1999				Mental Health (Public Safety and Appeals) (Scotland) Act		Changed the definition of mental illness to include

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
				1999		personality disorder.
1999				Ruddle Case		
1999			NHS MEL 73. Mental Health (Public Safety and Appeals) Scotland Act			
1999					Reid v Secretary of State for Scotland,	
2000	December	Reforming the Mental Health Act: White Paper				
2000	March	Home Affairs Committee, First Report, Managing Dangerous People with Severe Personality Disorder. GP/HC 42 1999-2000.				
2000			Atkinson and Patterson, Scottish Executive Central Research Unit, Review of Literature Relating to Mental Health Legislation			
2000			MacLean Report, Report of the Committee Violent and Sexual Offenders			
2000		Literature review for the MacLean Committee (Connelly and Williamson, 2000).				
2001	October				Retrial and conviction of Michael Stone for murder.	
2001					Galbraith v Her Majesty's Advocate High Court of Judiciary Appeal. The court clarified the definition of diminished responsibility by allowing a broader interpretation, based upon accepting the argument that	

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
					the courts had historically misinterpreted previous guidance issued to a jury by Lord Alness in the case of savage 1923. The appeal Court held that before criteria provided to the jury by Lord Alness will individual exemplar's of the doctrine of diminished responsibility and that any one of them was sufficient rather than a requirement that all four be demonstrated in order for a finding of diminished responsibility to be possible. The court however continued to explicitly exclude psychopathy as grounds for diminished responsibility.	
2001			Reducing the Risk, Improving the Response to Sex Offending, Report of the Expert Panel - Cosgrove			
2001			Millan Report, New Directions, Report of the Review of the Mental Health (Scotland) Act 1984.			
2001			Serious Violent and Sexual Offenders: Criminal Justice. Edinburgh, Scottish Executive			
2002	May	Conference: Mental Welfare Commission for Scotland. A National Conference on Services for Mentally				This also states that NHS MEL 1999 (5) "set out the guiding principles upon which services for

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
		Disordered Offenders in Scotland				mentally disordered offenders in Scotland should be based":30
2002	June	Reform of the Mental Health Act 1983: Draft Mental Health Bill				
2002					Galbraith v Her Majesty's Advocate	
2002	December		Positive Mental Health. SPS. This document refers to NHS MEL 1999 (5) and also to the World Health Organisation.			This document is quite progressive!
2003			Scottish Law Commission, Discussion Paper no. 122, Discussion Paper on Insanity and Diminished Responsibility. This report recommends that psychopathy and antisocial personality disorder should continue to be excluded from the definition of insanity but should effectively be brought within the definition of diminished responsibility.			
2003				Mental Health (Care and Treatment) (Scotland) Act 2003		
2003				Criminal Justice (Scotland) Act		Introduced the OLR.
2004	September	Revised Mental Health Bill. Cm6305. This Bill included an amendment to introduce Mental Health Tribunals.				
2004			Dangerous and Severe Personality Disorder, a Secure Services Planning and Delivery			

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
			Guide, Department of Health, Home Office			
2004				European Court of Human Rights. The proposals are in response to the 2004 European Court of Human Rights judgment involving an autistic man who lacked the capacity to consent who was kept at Bournewood Hospital…see notes.		
2005	July	Governments Response to the Report concerning the Revised Mental Health Bill				
2005	March		Report concerning the Revised Mental Health Bill, joint House of House of Lords Committee. HL 79-I / HC 95-I. This Committee Report contains a further rejection of the revised DSPD provisions the report recommended that separate legislation be introduced for this group.			
2005			Report of the Working Group On Services for People with Personality Disorder. This contains a number of important observations regarding the law and its implications for those who attract a diagnosis of personality disorder.			
2005			Atkinson, Scottish Executive, Review of Literature Relating			

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
			to Mental Health Legislation			
2005		Code of Practice, for the 2003 Mental Health Act.				
2005				Management of Offenders Etc. (Scotland) Act 2005		This legislation not only established Criminal Justice Authorities but also contained details of the scheme of accreditation for the RMA.
2006	March	Next Steps for the Mental Health Bill. Rosie Winterton announced that the government would bring forward a Bill to amend existing legislation rather than introduce an entirely new bill as in the form of the previous two draft bills. This will focus upon post release supervision of the treatability criterion.				
2006			Report of the Independent Inquiry into the Care and Treatment of Michael Stone			
2005			Atkinson and Reilly et al. follow-up Review of Mental Health Legislation. Scottish Executive.			
1999	24 June	Publication of The MacLean Consultation Paper				
2009		Article by Denise Coia entitled Mental Health Quality and Outcome Measurement and Improvement in Scotland				this article contains the following quotation: "Almost independent of the political party in power, Scotland has

YEAR	DATE	EVENT	REPORT / MEMORANDUM	LEGISLATION	RULING	CONCEPTS
						always been a country with broadly socialist leanings, based on its Calvinistic heritage":643. The article contains a very interesting overview of recent policy developments

Appendix 2: Service Readiness

Service Readiness - Key Attributes

- A postal address
- Photographic ID
- National Insurance Number
- Sufficient time and the absence of other competing demands
- such as childcare responsibilities
- The ability to recognise and appreciate financial incentives
- An absence of fear due to stigma, the threat of violence, perverse incentives such as those found in the informal economy or criminal situations
- Willingness to disclose personal information in surroundings which may be unfamiliar or uncomfortable
- Linguistic capacity (as defined by the service)
- Intellectual capacity (as defined by the service)
- Recognition of timeliness, deadlines, sanctions and penalties
- Trust in and willingness to behave respectfully and politely (as
- defined by the service) to staff

Appendix 3: Research Schedule

1.	**Following the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003, personality disorder is now for the first time included as a specific category of mental disorder in Scotland. What are you views of this change?**
2.	**In your experience do other psychiatrists / mental health officers view this change as a positive and welcome development?**
3.	**What changes, if any, has the inclusion of personality disorder resulted in :)1 for service users)2 for mental health professionals?**
4.	**In your opinion has the new Act resulted in more resources being made available to provide services for people with personality disorders?**
5.	**What difference has the Act made to the support available to those with personality disorders and any advice that you may offer?**
6.	**In your experience have services become more responsive to the needs of those with personality disorders since the new Act?**
7.	**As you will know, personality disorders have often been referred to as a diagnosis of exclusion; to what extent do you believe that this remains true?**
8.	**Based on your experience in what ways has the inclusion of personality disorder impacted upon service users?**
9.	**In what ways, if any, has the inclusion of personality disorder, resulted in service users participating more fully in decision-making processes regarding their welfare and treatment?**
10.	**In your view why was personality disorder included within the new Act?**

11.	**In your experience how are service users involved in deciding how their needs can best be met?**

12.	**In your opinion what has been the effect of the inclusion of specific principles such as non-discrimination within the Act?**
13.	**In your opinion, has the inclusion of any particular principles proved to be more significant than others?**
14.	**In your experience has the inclusion of personality disorder had any impact on the way other professionals work with you?**
15.	**In your experience do other professionals tend to focus more upon the needs of those with personality disorder or the risk that they might be seen to pose to others?**
16.	**In your experience how has the inclusion of personality disorder influenced the approach of other professionals towards the process of assessment and diagnosis?**
17.	**What policies and procedures has your organisation introduced as a result of the new Act concerning those with personality disorders?**
18.	**In what ways, if any, has the inclusion of personality disorder impacted upon your perception of your role?**
19.	**How has the inclusion of personality disorder impacted upon your own practice?**
20.	**In what ways, if any, has the inclusion of personality disorder impacted upon the roles of other professionals that you work with?**
21.	**What is your view about the treatability of personality disorders?**
22.	**Have your views about the treatability of personality disorders changed since introduction of the new Act, if so in what ways?**
23.	**What training and support have you received concerning personality disorders since the introduction of the new Act?**

24.	**In your experience does having a personality disorder make it any more or less likely that a CTO will be recommended? (If either more or less) - Why do you believe this to be the case?**
25.	**In your experience what factors make the application for a CTO more likely?**
26.	**Do you believe that the inclusion of personality disorder has made any difference to how you yourself work with those with personality disorders?**
27.	**How has the inclusion of personality disorder influenced your approach to assessment and diagnosis?**
28.	**What effect has the inclusion of personality disorder had upon your approach to treatment planning?**
General Comments by Respondents	

Appendix 4: Early example of analytical summaries

Collated Analytical Summaries of Nodes - Together with Stages One and Two of the Integrated-Analysis

As of 18th November, 2009

To date analytical summaries have been produced for 12 out of 56 nodes.

Analytical Summary - node Accepting Responsibility for the Service User:

Statutory services continue to be unwilling to engage directly with those service users who have the **most complex needs** i.e. many of those who are affected by the ***institutional closure programmes***. The voluntary sector has been recruited to work with this group of people, many of whom would include those who meet the diagnostic criteria for a variety of personality disorders. The **voluntary sector is effectively left to get on with working with these people** because the statutory sector argues that this is precisely what they have been commissioned to do. Those with personality disorders who repeatedly present to services, including crisis services tend to be regarded as **not having a real crises** and therefore are not appropriate for the service - this may reflect a much older bias within mental health services e.g. when crisis intervention was developed as a theory, if I recall correctly one of its basic ideas was that a crisis would not normally last for more than **14 days**. The idea of someone therefore being in almost perpetual crisis is indeed inconsistent with this fundamental approach and therefore at odds with services that are based on models of crisis intervention. A process of **buck-passing** is evident in which professionals tend to be reluctant to accept responsibility for on-going work with those with personality disorders. Once engaged **other professionals also tend to drop out** leaving social workers to carry on. The tendency for workers to become frustrated with those with personality disorders also continues this is exemplified by the refrain "**why can't you just help yourself**". It is also clear that **formal patients continue to receive a far more adequate service than informal patients**, precisely because the procedural requirements incorporated within the new legislation are more rigorous in respect of formal patients and specifically treatment plans. Psychiatrists have increasingly moved towards a position in which personality disorder is seen to be inevitably an **unavoidably a legitimate** aspect of their work. The current state of **cultural change** appears to be one based on **practical acceptance** of the inevitable and a recognition that it is not

unreasonable for those with personality disorders do want to gain access to psychiatric services - this is reminiscent of the **realpolitik** approach which also appears to have influenced the Millan committee in its deliberations concerning whether personality disorder should be formally included as a category. This cultural change does appear to represent a **challenge for psychiatrists** however, not least in respect of their own **confidence** regarding their skills and abilities. The **arbitrary distinction** between antisocial personality disorder and borderline personality disorder is also acknowledged by one psychiatrist who acknowledged that psychiatrists probably should be working with those with antisocial personality disorder also. This position does run contrary however to the official stance of the Scottish government and probably psychiatry more generally within Scotland.

Distillation and Further Reflection Upon - Analytical Summary - node Accepting Responsibility for the Service User:

A division can be seen between the statutory and voluntary sector which is based upon the statutory sectors recru effectively undertake some of the work that it does not wish to do. Perhaps unsurprisingly this includes working v regarded as a the most challenging and have the most complex needs. This group is populated to quite an exten by the institutional closure programme of recent years. A further process is evident whereby when professionals person with personality disorder, they tend to try and disengage thereby leaving someone else, presumably anyo for the service user. A further distinction continues to be evident between formal and informal patients with the e resources being placed heavily in favour of formal patients in order to comply with the requirements of the curren change can be identified however; with psychiatrists increasingly accepting the inevitability if not the desirability o a diagnosis of personality disorders. This raises a number of challenges not least relating to confidence amongst

appear to feel that they have the necessary skill set. An arbitrary distinction continues to be evident as consisten that those with antisocial personality disorder should be deemed to be undeserving and bad and those with borde increasingly viewed as deserving and entitled to services under the broader historical category of mad.

It is definitionally inherent within the concept of crisis intervention that a crisis is: "An acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment" (Roberts and Ottens 2005) p 331. I.e. that it must therefore be short lived - as distinct from a more or less permanent pattern of behaviour. This provides some justification or at least a rationale for why crisis services may be reluctant to engage or take on people with personality disorders. This would potentially at least lend weight to those who argue in favour of specialised services - i.e. a service which is capable of responding in a coherent manner to a repeated pattern of crises.

A number of distinct polarities have been identified above which relate to the previous polarities that I have identified: see my research log dated **Wednesday, 21 October 2009**.

Analytical Summary- Node Access to Assessment:

Access to assessment appears to be very significantly influenced by factors concerning boundaries and values; rather than the actual disorder that a patient may or may not have. Specialist services have on occasion opened up hitherto closed roots to assessment i.e. the Homeless Personality Disorder Team; however specialisation has also resulted in concerns that the boundaries around particular teams, reflected in their criteria, mean that some individuals may actually find it harder to be assessed in the first place. Whether or not an individual is assessed as having a personality disorder, would appear to have a good deal to do with the values and beliefs of those charged with the responsibility for conducting the assessment; rather than being dependent upon the clinical factors that pertain to any given patient. The Millan committee clearly did not see any significant change to the entitlement to assessment, taking as they did a fairly resource led approach.

Analytical Summary - Nodal Analysis of Borderline Personality Disorder and Psychiatry:

A clear focus can be identified upon **management**. One psychiatrist suggested that psychiatrists were best placed to undertake this management function in respect of BPD but not with regard to antisocial or psychopathic personality disorder. This was to some extent based upon the practical reality is that people with Borderline Personality Disorder "will always present to psychiatric services". One of the ways historically the psychiatrists have tried to manage this group of patients is by seeking to avoid working with them! I.e. management by exclusion. The practical reality however is that such patients do tend to be admitted and represent a significant demand upon in-patient beds. One of the reasons for the reluctance to acknowledge formally working with this group has also been concerns about stigmatisation. The reality however is that according to a least one survey **one in six** of inpatients were admitted because of borderline personality disorder and tended to spend "one year out of three, as an inpatient". A significant "financial imperative" as well as potential benefits in improving the quality of services are driving a move towards more coordinated approach is to working with those with Borderline Personality Disorder in the community in certain areas. This could perhaps be summarised as **managing patients and amending budgets**. Borderline personality disorder "has almost become synonymous with" personality disorder. This appears to be largely a consequence of the way in which the available **research is skewed** towards personality disorder, such that other forms of the disorder tend not to receive the attention of researchers. There appear to be to drivers for this: the first that this particular group of patients are fairly **high profile** and therefore stimulate a political **imperative** for something to be done. The second consideration is that because this group of patients do as a practical reality find their way onto the case loads of psychiatrists, because **psychiatrists are in a position to dispense medication**, this particular group also therefore gets the attention of pharmaceutical companies are also in a position to fund research. This means that those with other types of personality disorder

e.g. anxious avoidant are still likely to be viewed as "mildly irritating" and their disorder to be viewed as a "therapeutic obstruction" rather than a proper focus for treatment. This echoes the *Patients That Psychiatrists I Dislike* research paper of some years ago. This 'medical' orientation i.e. an emphasis upon prescribing can also be identified within the **Integrated Care Pathway** for borderline personality disorder which gives more consideration to medication than anything else.

Analytical Summary - Nodal Analysis Care Pathways:

A significant difference of opinion can be seen between a key government official and a key informant from the voluntary sector. The first regards the inclusion of personality disorder as part of a coherent strategy of deliberate inclusion, which is part of a wider health care strategy (I need to see my reflective journal and go back and look at the policy developments in England and Wales i.e. find the parallel policy document that I discussed in supervision). The informant from the voluntary sector was very sceptical that the ICP would actually have any practical impact because it was unwieldy and because of the prevalence of hostile attitudes towards those with personality disorders. The psychiatrist that-I interviewed who worked on the integrated care pathway, also expressed or degree of disappointment that the ICP was very minimal but balanced this by suggesting that one of the reasons for the minimal approach was that a number of the standards that the working group recommended were absorbed within the more general standards. There was an implied regret however that the ICP as it currently stands focuses upon medication.

The fact that this node only has three respondents worth considering should not lessen its importance. The respondents were a government official overseeing the whole process, a key informant from the voluntary sector who was an active participant in the process on behalf of their voluntary organisation together with a psychiatrist who was both on the MacLean committee and also helped to write the standards for the ICP.

Analytical Summary Node - Clinical Concepts of Treatment:

Perhaps unsurprisingly the diagnostic status of personality disorder continues to be regarded as somewhat contentious. A division appears evident between newer and more established psychiatrists based on the fact that those that are newer to the profession tend to focus more upon treatment planning in terms of what is specifically deliverable. In more general terms, in respect of personality disorder, clinicians appear to be adhering to a fairly traditional model of treatment rather than embracing the much broader definition contained within current legislation. Borderline Personality Disorder has effectively become synonymous for most practical purposes with the term personality disorder. This is largely because of the growing evidence base concerning effective interventions for those with this diagnosis. One of the consequences however is that other forms of personality disorder tend still to be regarded in negative and perhaps even hostile terms. As anticipated, compulsory measures are generally seen as irrelevant to working effectively with those with personality disorders: the emphasis is upon co-operation with service users. The *Scottish consensus* regarding the division between antisocial personality disorder and other forms of personality disorder has generally been maintained; however there is evidence that some psychiatrists are becoming increasingly open-minded about the possibility of working with those in the antisocial group.

Analytical Summary - Node Diagnosis of Exclusion:

A clear policy distinction can be identified between antisocial personality disorder and borderline personality disorder. The former is marked for exclusion at the policy level and the latter for inclusion. This can be understood as an example of the very old division between the deserving and the undeserving and also the archetypal mad/bad division identified by Foucault and others. In this case those who are perceived as deserving of health based interventions. Social workers identified a continuing tendency for the established practice of keeping the doors firmly shut to influence decision-making within CMHTs. A further distinction was also identified to in those who are perceived as representing a high degree of risk and therefore receive considerable attention on those who are perceived as representing a low-risk and therefore receive very little attention. Where interventions to take place, they appear to be focused on managing problematic behaviours rather than addressing the needs of individual concerned. The clarity within the current legislation regarding the need for treatment plans appears to act as a disincentive for some psychiatrist to use formal powers in respect of personality disorder; this is generally in keeping with the Millan Report and assumptions concerning the use of compulsory measures. Personality disorder still continues to be perceived as somebody else's problem as far as CMHTs are concerned i.e. they appear to define their role in terms of mental illness. Psychiatrists tended to identify a shift in practice over time, which tends to be referred to as a cultural shift. This amounts to a shift away from exclusionary practices towards a positive policy of inclusion. Exclusionary practices are perceived as having failed because of the reality of the number patients admitted to hospital that have a personality disorder(s). As part of a broader cultural shift personality disorders are also increasingly perceived to be a legitimate area of concern for psychiatrists. The shift

towards inclusion was however not without difficulties; problematic behaviour still continues to be seen as a basis for exclusion and rejection. Inclusion appears to be limited to borderline personality disorder; other forms of personality disorder are likely to be viewed in a more traditional manner i.e. as a source of therapeutic obstruction. This raises possibility that patients with these other forms of personality disorder may also come to be viewed as a source of irritation (see Lewis and Appleby paper).

Analytical summary - Node Difficult to Manage and Problem Patients:

At a policy level exclusionary practices in respect of antisocial personality disorder are officially endorsed. The main focus of inclusion concerns borderline personality disorder. Statutory services (local authority) continue to be reluctant to engage with those with personality disorder, preferring to leave this to specialist providers. One of the consequences of this appears to be a degree of ongoing marginalisation and exclusion, at least from mainstream services. Social workers are committed to working in accordance with their value based in order to promote an agenda of inclusion; however this frequently results in significant levels of frustration regarding the difficulty of actually engaging with people with personality disorder and the general lack of services available. Those people who are retained on the case loads of community mental health teams, are frequently characterised by the so-called revolving-door syndrome, and can come to be viewed with the degree of frustration and hostility by staff. The response from community mental health teams can become polarised whereby those who are perceived to represent a significant risk (particular forensic patients) receive a high level of intervention, where as those who are not perceived as representing a significant risk to others are often left to the bottom of the pile. Where interventions do take place the focus tends to be on the management of behaviour, rather than addressing

individual needs at a more fundamental level. Cultural change appears to be taking place within psychiatry; however as may be expected more *traditional* attitudes do also continue, exemplified by a fairly punitive focus upon boundary violations, social conformity and individual responsibility. Continued and frequent boundary violations are still viewed by some staff as a basis for not working with people with personality disorders, not least because of the risks associated with certain behaviours, particularly those associated with self-harm. This indicates that a form of objectification continues whereby the individual is viewed in terms of a cluster of behavioural indicators, which require to a greater or lesser extent to be managed in order to maximise their social conformity and increase their survival chances. Where this arises the emphasis is one of management rather than addressing the well-being of service users at a more fundamental level. The more progressive position is one which recognises that previous attempts by psychiatrists to actually exclude those with borderline personality disorder from mental health services, has in fact failed – as indicated by the reality on the wards. The progressive view unsurprisingly places an emphasis upon the person and the need to establish effective therapeutic relationships, whilst also at the same time recognising the need to acknowledge the significance of particular behaviours. This progressive approach shares with social work a belief that perseverance despite the obvious difficulties and challenges is necessary and appropriate.

Comments: I believe that this node can be combined with another node namely; Diagnosis of Exclusion. This is because, it seems to me, that to some extent this node serves the function of explaining the other i.e. Diagnosis of Exclusion.

Analytical Nodal Summary – Joined-up Services and Specialisation:

Social workers perceive increasing specialisation to be problematic because it increases the possibility that those with personality disorders may fall through gaps in service provision. The illusion of specialist knowledge great additional problems because those who may be perceived as having expertise moved fairly frequently between teams meaning that in fact they may not possess the knowledge or understanding that others or indeed they themselves may assume. Increasing specialisation within the MHO role also means that MHOs are in danger of being cut off from other workers. This has particular implications for those with personality disorders, given that the does not appear to be any particular emphasis within the MHO role in training regarding the development of a greater understanding and skill set these are the personality disorders.

Psychiatrists appear to continue at least in some instances to take a fairly traditional view of their role vis-a-vis pharmacological interventions. One response to this is to argue that court will change will take too long and that more specialised services are required in order to try and reduce the tendency for people to "bounce about" because they're not seen as legitimate patients not having severe enduring mental illness. This represents a specific form of exclusion which is not in the spirit of the act but nevertheless represents a fairly pragmatic response. Despite efforts to keep those with personality disorders out of the system, a significant number of those admitted i.e. one in six of all patients, according to one study had a diagnosis which included borderline personality disorder. One response to this is to emphasise the potential financial savings that could be achieved by providing better services in the community and therefore preventing these admissions. The law would not appear to have been particularly influential upon psychiatric practice largely because its focus is upon detention

and compulsion. This focus, as indeed anticipated within the Millan Report, would generally not be applicable in Scotland for people with personality disorders.

Analytical Summary - Node Lack of Service Provision:

Differences in the provision of specialist services in Scotland and England are very evident to policymakers, psychiatrists and also to service users (this was not indicated however by social workers). These differences exist because of the very different policy trajectories that have been adopted and pursued within these two jurisdictions. The pressure to provide specialist services is likely to continue, coming from would be provided as and also from service users. Access to psychological services and also to appropriate psychiatric services continues to be problematic and generally perceived as lacking. Trying to access appropriate services for those with personality disorder continues to be an ongoing "battle". Recognition of the mortality and suicide rates associated with borderline personality disorder however may provide some impetus in the process of providing better community-based alternatives to admission. This also has the benefit of offering significant financial savings. The law would appear to only have a secondary importance with regard to what services are actually provided.

Analytical Nodal Summary - Node Legislation Makes No Difference:

The law itself does not appear to have had a significant part in any changes that have taken place vis-a-vis the services available to those with personality disorders. Changes that have taken place have tended to be driven by other contingencies e.g. the hospital closure programme and are supported by a broader change in the relationship between doctors and patients. An increased emphasis upon patient's rights can be seen as influencing the more open attitude towards those with personality disorder and indeed appears to have influenced the drafting of the 2003 Act. The shift towards a more positive attitude is however by no means universal; with a tendency by some medics to a dear to fairly traditional definitions and interpretations of illness and treatment - despite the fact that the definition of treatment is now so expensive. The competition for scarce resources seems to be much more significant in determining what services are provided and to whom than the law itself. Based on this assessment, one would not predict a particularly positive future in terms of service provision for those with personality disorders.

Analytical Summary - Node Resource Implications:

At a policy level part of the rationale for taking a radically different approach to the forensic and general population appears to be based on cost. The cost implications of developing specialist services for those with a diagnosis of ASPD, is considered to be prohibitive and to amount effectively to a moneymaking exercise for private companies. The cost implications of specialist provision, although in the case referred to this was BPD, was also emphasised by a social work practitioner who quoted £3000 a week as an example. The lack of resources was

identified as a one of the drivers behind the establishment of the personality disorder network. Interestingly however a leading psychiatrist took a different view, arguing that the decision to finance the establishment of a network was the correct way to proceed. This was based on the belief that the alternative would be to fund specialist provision along similar lines to those in England and Wales. This particular psychiatrist regarded that as a fruitless and ineffective pathway to follow. The network was seen as a more effective means as well as a more economical means of promoting best practice. Resources appear to be constraining the provision of DBT and psychological services more generally for which there are excessively long waiting lists. With the exception of one psychiatrist who did not appear to regard resources as a significant consideration, it appears that psychiatrists regard existing services as inadequate for a number of reasons. Currently services have to be "cobbled together" partly because of entrenched attitudes and the fact that in the clamour for resources, more clearly recognised medical conditions such as schizophrenia tend to win over personality disorders. One of the consequences of these entrenched attitudes and the slow pace of cultural change, was the suggestion by one psychiatrist that specialist dedicated resources were needed. Clearly such an approach would have very significant resource implications. One psychiatrist indicated that where better community-based provision had been provided, that this had a positive impact upon resources in so far as it had made bed closures possible. This psychiatrist suggested that there was a "financial imperative" to provide community-based services and that his attempts to do so amounted to a "natural experiment" which had proved successful. The potential demand for services in respect of personality disorder appears to outweigh any realistic potential for future resource provision: consequently the "fear of being engulfed" contributes to a situation in which the under diagnosis of personality disorder is almost systematically encouraged.

The question of resource constraints becomes even more significant bearing in mind the comments of one of the key informants i.e. that resource constraints were far more significant than legislation itself in determining what services were provided and to whom.

Analytical Summary- Node Training:

Social workers indicated that they had **not received any particular training in respect of personality disorders to help them implement the 2003 Act**. Specific training had been provided in terms of mentally disordered offenders, which are increasingly influencing the case loads of some CMHTs; however this training did not consider personality disorder specifically.

Psychiatrist indicated that they had **not received any specific training concerning personality disorder in order to help them implement the 2003 Act**. Psychiatrists and furthermore indicated that they didn't necessarily feel that training was sufficient in order to allow them to communicate effectively with people with a diagnosis of personality disorder posts in the fact that doctors are "**not necessarily trained to have that skill set**". The efficiency of providing specific training in packages such as DBT was also called into question on the basis that on occasion people use this as a route to career advancement rather than putting their knowledge and skills into practice subsequently. The Scottish government does appear to be supporting training in respect of psychological interventions are to be CBT and mentalisation.