Personality Disorder and Community Mental Health Teams

A Practitioner's Guide

Edited by

Mark J. Sampson and Remy A. McCubbin
Manchester Mental Health and Social Care Trust

Peter Tyrer
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SECTION TWO TREATMENT AND MANAGEMENT IN COMMUNITY MENTAL HEALTH TEAMS

About the Editors

Mark Sampson works as a clinical psychologist in two Community Mental Health Teams (CMHTs) in South Manchester. He has been a part of these teams for the past five years and during this time developed experience and expertise in working with patients with personality disorder. He originally trained as a general and psychiatric nurse before studying psychology, obtaining a doctorate in clinical psychology from the University of Manchester in 1999. He uses integrative approaches to working with patients with personality disorders, but is strongly influenced by cognitive and cognitive analytic therapies.

Remy McCubbin first studied Biology at Southampton University, graduating in 1987. He went on to study for a MA in Psychology at Nottingham University, graduating in 1993, before working on an evaluation of three CMHTs in the Midlands. In 1998 he completed a doctorate in clinical psychology, since which time he has worked across several community teams in South Manchester. This has inspired an interest in personality disorder, and has led to a recognition of the importance of such difficulties in the response to treatment of many people seen by these services. He has an interest in several forms of therapy, and the potential advantages of integrating various approaches within multi-disciplinary interventions. Away from personality disorder, he has an interest in the role of affective avoidance in the maintenance of various Axis I and Axis II disorders.

Peter Tyrer is the Head of the Department of Psychological Medicine at Imperial College, London, Honorary Consultant in Rehabilitation Psychiatry, Central North West London Mental Health NHS Trust, and Honorary Consultant in Assertive Outreach (IMPACT team) in West London Mental Health Trust. He obtained his medical qualifications at the University of Cambridge at St Thomas's Hospital London in 1965 and trained in

psychiatry at the Maudsley Hospital and Institute of Psychiatry, London. He has carried out research into personality disorder since he was a medical student and has published two books and over 100 original articles on the subject. He is the founder president of the British and Irish Group for the Study of Personality Disorders and the Co-Chair of the Section on Personality Disorders of the World Psychiatric Association. He is a Fellow of the Academy of Medical Sciences, of the Faculty of Public Health, of the Royal College of Physicians, and of the Royal College of Psychiatrists. He is the Editor of the *British Journal of Psychiatry* and on the editorial board of seven other journals. Despite his academic interests he still regards himself primarily as a 'coal-face' psychiatrist, who has learnt most from his patients—and among the most stimulating and challenging of these have been those with personality disorder.

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Preface

In the UK, recent government proposals have emphasised that people with personality disorder are seen as 'legitimate business' for generic mental health services and, therefore, for community mental health teams (CMHTs). These proposals have been welcomed by many working in the field, and should in time help to prevent people with such difficulties being excluded from mental health services.

However, many practitioners working in CMHTs are currently unsure how best to support patients with these types of problem. The idea for this book came from observing and experiencing the struggles that CMHTs can go through when trying to develop effective care plans for people with personality disorder.

It is our hope that the book accurately conveys a sense of the considerable distress that is often associated with personality disorder—distress not only for the patient, but also for their friends and family, and for those working in services trying to help them. We then hope to provide useful ideas about how CMHT practitioners can work more effectively, to support each of these groups. The book has deliberately been aimed at the 'non-specialist' CMHT practitioner, i.e. someone who does not already have a detailed knowledge of the literature relating to these patients. For those who do wish to read further, however, each chapter also provides an overview of key references contained in the wider literature.

The book is divided into two sections. In the first section, recent government initiatives relating to personality disorder are outlined, and ideas underlying psychological and biological treatments are introduced. The second section focuses specifically on the particular roles and functions of the CMHT, in trying to support patients with these disorders.

Figuratively speaking, the 'tent' for personality disorder is set up in Chapters 1 and 2, and the theoretical concepts pinning it to the ground (by not particularly sturdy guy ropes) are described in Chapters 3 and 4. Each

guy rope relates to a specific treatment or group of treatments, and the nature of each is set out in Chapters 5–7. It is important for the reader to realise that the accounts contained in these chapters present their 'product' in the best possible light, and do not always take account of the problems that are encountered in practice. These problems are illustrated in Section Two, which emphasises the importance of the fundamental concepts of 'engagement' and 'alliance' and that there is no simple formula or protocol that provides all the answers.

This book does, however, contain a framework around which CMHTs are able to structure their thinking. The evidence base for many of the interventions used for personality disorder is at present a small and unstable one. Because we have so little that is really solid—there is, for example, no intervention effective enough to be published in a NICE guideline—it is tempting to clutch at the favourable results that are published and make as much of them as we can. In such a climate, there can be an incentive to exaggerate the evidence for certain approaches. This would be unfortunate and, ultimately, unhelpful. While we should not be pessimistic about our efforts in CMHTs to tackle personality disorder effectively, we should acknowledge that much of what we describe is 'patient-based evidence'. This is useful, but it is only a beginning. There is an old Ghanaian proverb, 'a man does not know how far he has to go until he starts walking'; this book represents the start of what is likely to be a long march.

Some comments should also be made regarding the terminology used in this book. While acknowledging the difficulties associated with a diagnostic approach and the term 'personality disorder', this terminology is at present the one most widely used and most readily understood, and as such allows for the clearest communication of ideas. We have also chosen to use the term 'patient' rather than, for example, 'client' or 'service user'. While this might seem peculiar—especially when many of the challenges for services arise *because* people with these difficulties do not easily fit with an 'illness' model of care—we do believe it is helpful to be reminded that CMHTs operate in a psychiatric system heavily influenced by a medical model of 'illness'.

Personality disorder has been largely ignored or denied in much of psychiatric practice, which has typically hidden behind terms such as 'resistant depression' and 'simple schizophrenia', instead of acknowledging that it is personality factors that are responsible for much of the variation in clinical response and outcome that we see in practice. Practitioners who have been puzzled by this variation (often to the point of questioning their own competence) will hopefully be encouraged to realise that much of this variation can be put down to personality in all its aspects and that these

factors can be amenable to intervention. In our view, patients with personality disorder are an extremely rewarding group of people to work with. We hope this book will help to inspire interest and confidence in such work among CMHT practitioners.

Mark Sampson

Remy McCubbin

Peter Tyrer

SECTION ONE

Theoretical Background

1

Personality Disorder: New Initiatives in Staff Training

EDDIE KANE

INTRODUCTION

A good deal is already known about personality disorders. There is also an increasing understanding of what is helpful and unhelpful for people with these disorders. It is therefore important to communicate this knowledge to the increasing numbers of staff, in a wide range of agencies, with whom they come into contact.

With a few notable exceptions, clinicians have for years tended to avoid involvement in the treatment and support of people with personality disorders. Tolerance of these attitudes is rightly declining. This change in attitude has been well supported by new Guidance from the National Institute for Mental Health in England (NIMHE, 2003a, 2003b) developed in the wake of the National Service Framework for Mental Health (Department of Health, 1999). Relatively small sums of new national money have been used to stimulate the growth of new and sometime novel services. As well as service development, training for staff is becoming a higher priority.

Despite these encouraging developments and changes in attitude there is a long way to go. People with personality disorders are still one of the most socially excluded groups in our society. Their experience of services from a wide range of agencies demonstrates a lack of tolerance and awareness of their issues and of them as individuals. Other chapters in this book aim to help redress the situation by offering readers an opportunity to be more

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aware of personality disorders, the people who experience them and the techniques and support systems that can help them.

BACKGROUND

Recent initiatives from the UK government to improve services for people with a personality disorder have raised the profile and the importance of staff training for a wide range of staff engaging with patients with these problems. No longer can training be the preserve of a minority of interested professionals. Rather, it will need to move centre stage for a much wider range of people, in many different agencies. An appreciation of current thinking and the development of best practice is important for anyone involved in delivering community-based services. In particular, working with people with personality disorders is likely to become an essential area of required expertise for Community Mental Health Team (CMHT) members.

The competencies required for working with people with personality disorders are in many respects similar to those needed to work with other individuals with a range of mental disorders. However, there are some clear differences. Direct professional involvement in the area of personality disorders demands a high degree of personal resilience, the ability to maintain good boundaries and manage hostility and conflict. Individual members of staff also need to be multi-disciplinary team players and be able to appreciate the value of team working and support. Just as important is the ability to tolerate and manage the emotional impact on the multi-disciplinary team's functioning that intensive working with people with a personality disorder can create.

Recent work by the National Institute for Mental Health England (NIMHE) has begun to firm up the agenda for staff training and suggests an integrated 'Skills Escalator' as the most effective framework for staff training and development.

This chapter will:

- discuss the context for the recent government and NIMHE initiatives to improve services for people with personality disorders
- outline these initiatives, particularly those related to staff training
- reflect on how these initiatives could help CMHTs work more effectively.

Taking this training and development framework forward is perhaps one of the most critical areas of mental health services in which progress needs

to be made nationally. Without such progress, people with personality disorders will remain one of the most excluded groups of individuals, will be denied relevant and sensitive services, and will continue to be vulnerable in our society. This is a future that ought not to be contemplated in 21st century Britain.

A FRAMEWORK FOR REFORM

The National Service Framework for Adult Mental Health (NSFMH) (Department of Health, 1999) describes a clear set of responsibilities. These responsibilities focus particularly on the provision of evidence-based and effective services for all people with mental disorders, including those with personality disorders (who are debilitated and excluded as a result). As part of the practical implementation of the NSFMH, in January 2003 the National Institute for Mental Health in England published *Personality Disorder: No Longer a Diagnosis of Exclusion* (NIMHE, 2003a). The guidance was intended to build on standards four and five of the NSFMH, and to ensure the development of specific services for people with personality disorders.

The guidance started from the premise that personality disorders are common and often disabling conditions. Many people with personality disorders are able to manage their lives and relationships successfully on a day-to-day basis. However, there are a significant number of individuals who suffer a great deal of distress. These individuals often receive few or no tailored services and their interactions within their social and their service networks are frequently dysfunctional, and unsatisfactory to themselves and the people to whom they try to relate. Few National Health Service (NHS) organisations and even fewer of the other potential service-providing agencies have specific services for people with personality disorders. In 2002 only 17 per cent of NHS Mental Health Trusts provided a dedicated service for people with a personality disorder (NIMHE, 2003a). The situation is compounded by the fact that even where there is dedicated provision, the services are based on widely varying and occasionally conflicting therapeutic models and approaches. As a result, people are frequently treated or supported at the margins—for example, in Accident and Emergency departments, through inappropriate admissions to psychiatric units, lost in a CMHT's caseload or as frequent and unsatisfied attendees at a GP's surgery.

Underlying this unsatisfactory state of affairs is the belief amongst many mental health and social care professionals that there is nothing that people with a personality disorder can be offered that would help them move

towards recovery and an improved ability to cope with everyday life. The guidance also highlighted the danger that the proposed changes in the draft Mental Health Bill would emphasise even further the enormous gap in services and skills by removing the so-called 'treatability test', which has been frequently used as a way of excluding individuals from treatment, particularly by mental health service providers. In effect, some of the most damaged and excluded people in society are refused treatment because individual clinicians make decisions based on their view that people with a personality disorder will not respond to any interventions they have at their disposal. This process of exclusion is legitimised by the current Mental Health Act, which specifies that an individual must be deemed to be treatable before treatment is offered.

Clearly, this was not a position that could continue if the government's commitment to modernise services was to be delivered. Not only was new investment needed in direct service provision, but also a major initiative was required to provide new training opportunities to ensure that not only clinicians and practitioners but also staff in a wide range of agencies had access to training, ranging from 'awareness training' to specific high-level treatment skills.

In summary, *Personality Disorder: No Longer a Diagnosis of Exclusion* (NIMHE, 2003a) recommends that services should:

- Assist people with personality disorder who experience significant distress or difficulty to access appropriate clinical care and management from specialist mental health services.
- Ensure that offenders with a personality disorder receive appropriate care from forensic services and interventions designed both to provide treatment and to address their offending behaviour.
- Establish the necessary education and training to equip mental health practitioners to provide effective assessment and management.

Translating these specific aspirations for personality disorder services into action on the ground has become one of the major challenges for mental health and other services providers, trying to deliver the spirit and the targets set out in the NSFMH. However, the publication of the guidance, the promise of new money and the setting of specific delivery targets for the NHS has led to a focus on these services as areas where performance improvement is expected by the Department of Health, NHS Trusts, Strategic Health Authorities and Primary Care Trusts. This in turn has stimulated a number of developments aimed at improving services, and appears to have introduced tentative discussions about 'recovery', aligning

clinical and organisational responses to people with personality disorder to the mainstream of modern mental health policy and development.

Amongst the developments are 11 new, community based services funded by the Department of Health. These new services are very diverse. Some are to be provided within specialist mental health services, others will be run directly by service users and another group will be delivered through local voluntary organisations. The client groups being targeted through these new services are equally diverse. They include young people, adults and those who have severe substance misuse problems. It is hoped that with the establishment of these new services, and their subsequent independent evaluation, there will be a significant shift upwards in the evidence base about what works and what does not work in treating and supporting people with personality disorders. The evaluation of the bids to provide these new services has had close involvement from a national service user reference group. This group was instrumental in making the final choices and their opinions genuinely weighed as heavily as those of their colleagues from the statutory agencies. After such a positive experience, it is hoped that the pattern of closer involvement of service users in developing and evaluating services will become the norm for services to people with personality disorders, which in the past it certainly has not been.

THE TRAINING GAP

The key to delivering new services and transforming the response of existing mainstream mental health and social care services for people with personality disorder is the development of a workforce that is more aware of the issues that affect people with personality disorders and the way they react to them. This should be a *minimum* requirement affecting staff in many agencies, both statutory and voluntary, which provide a wide range of essential services including housing, emergency and primary care, employment and benefits advice. Developing personality disorder awareness is important if staff are to better understand the behaviours and attitudes with which they may be presented from time to time, and be able to respond more effectively. It is also a vital ingredient in challenging the stigma that is associated with the diagnosis of personality disorder. To date, that label has more often than not resulted in the exclusion of people from help and support, and has restricted their ability to participate properly as full members of society. The weight of stigma is still a major obstacle for individuals attempting to seek help with their problems. It is fuelled to a large extent by the absence of personality disorder perspectives in

mainstream professional training. This difficult and perverse position is summed up well by the following observation: 'In Britain we have the remarkable phenomenon that large numbers of quite severely disordered people who require considerable therapeutic effort are deemed untreatable' (Gunn, 2000).

Although a vital component of service reform, personality disorder awareness is not of itself sufficient. There is also a need for some staff groups to develop new ways of working with people with personality disorder, drawing on the currently small but expanding evidence base, to find ever more effective interventions and support mechanisms. These staff groups are in a wide range of agencies and often in roles not traditionally associated with delivering services to people with personality disorders. In the background survey work carried out prior to the development of *Personality Disorder: No Longer a Diagnosis of Exclusion*, groups other than those traditionally associated with delivering services to people with a personality disorder emerged as high priorities for new training initiatives. These groups included health visitors, district nurses, junior doctors in Accident and Emergency departments and local authority housing officers. New ways of delivering training to these groups need to emerge and existing training technologies need to be adapted to meet what is a growing need, which will translate into a growing demand for relevant, accessible and high quality training programmes.

TRAINING INITIATIVES: THE NATIONAL CONTEXT

The new service developments for people with personality disorders are taking place in a rapidly evolving mental health training and educational context. This evolving context includes new structures and partnerships, as well as the arrival of new players. Key to these new programmes and partnerships are the Regional Development Centres of NIMHE. Each of the regional offices has the responsibility to work with a broad range of local agencies delivering services to people with personality disorders, and has been given funding to help move the training and development agenda forward.

The regional initiatives already underway comprise a wide range of approaches and objectives. For example:

- pilot 'personality disorder awareness cascade' courses
- mapping of existing training programmes
- development of multi-stakeholder training specifications

- development of CD-ROM and internet-accessed training packages
- tailored training for primary care staff.

In addition to developing tailored training packages that reflect local need, there is much still to be done to embed awareness of personality disorders into the pre- and post-registration education. Key targets are clearly professionals working directly in therapeutic relationships, but also other professionals who come into contact with people with a diagnosis of personality disorder, including GPs and other primary care staff. This breadth of approach is vital if effective and co-ordinated support networks for individuals are to be established.

There is evidence of an encouraging recognition of the need to change both pre- and post-registration training to incorporate the dimension of personality disorder, by several of the key national registration bodies. These include the Royal College of Psychiatrists (RCoP), the British Psychological Society (BPS) and the Nursing and Midwifery Council (NMC). There is also growing enthusiasm from organisations such as the Prison Service, which at any one time has custody of large numbers of people with personality disorders and whose staff are often ill equipped to develop or deliver a productive set of interventions.

It is also important to acknowledge that whilst good quality, multi-disciplinary training is in short supply it does exist. There are some examples of existing good practice, including well established training programmes, manuals and other training materials. These at least represent a foundation for future national, regional and more local developments and consideration needs to be given to how best to apply these tools to new and wider audiences. One possibility which has been discussed is the development of a 'capability benchmark' process for these products and programmes, which would act in the same way as the quality kite mark in ensuring consistent standards. The benchmark process would be led through NIMHE and its education partners. Assessing the quality of existing training programmes and media will be an important first step.

When there so obviously remains a great deal to be done, with new programmes and media to develop, it is easy to start re-inventing the wheel and fragmenting the development programme. Whilst needing to avoid such fragmentation, one area that requires immediate attention is the involvement of service users in the development and operation of training programmes. A key characteristic of the national development programme running through the NIMHE regional offices has been the close involvement of service users. It is important that this pattern is reflected as other agencies and initiatives move into this area of work. The involvement of service users must go far

beyond the traditional representational and consultative roles and engage with the training needs of service users themselves and their involvement in the delivery of professional and awareness training.

A NATIONAL TRAINING FRAMEWORK

There is a need for exponential improvements and increases in training availability to secure improved services and learn from new developments and evidence. If this is to be delivered consistently around the country, it requires a framework to which people can refer and through which people can make sense of the various other training initiatives, related to current general mental health service developments. In order to provide such a framework, NIMHE carried out a detailed piece of development work involving a wide range of experts, including service users. The result was the publication of *Breaking the Cycle of Rejection: the Personality Disorder Capabilities Framework* (NIMHE, 2003b). The framework highlights some of the critical capabilities that are appropriate to interactions with people with personality disorders and that are required by staff at all levels and in a variety of agencies. The framework was not designed to be a definitive work. Rather, it describes a process which will be enhanced and changed over time as knowledge expands and services develop. The framework builds on a number of basic principles that are designed to break the 'cycle of rejection', which is the experience of many people with personality disorders. It starts from the premise that developing responsive and sensitive services for people with personality disorder is possible and will promote social inclusion and deliver better outcomes.

The underlying principles of the framework are that training:

- should be based on respect for the human rights of service users and their carers
- programmes should consider how best to reflect the views and experiences of service users and carers
- should be aimed at breaking the cycle of rejection at all levels, including self-rejection, the social support system, practitioners and the wider health and social care systems
- should encourage service user autonomy and the development of individual responsibility
- should be multi-agency and multi-sectoral
- should support team and organisational capacity as well as that of individual practitioners

- should be connected to meaningful life-long learning and skill escalator programmes
- should be based on promoting learning in approaches to treatment and care that are supported by research evidence, where it exists.

These principles were derived from *Personality Disorder: No Longer a Diagnosis of Exclusion* and from the work of an expert advisory group and a service user focus group. The aim of the framework is to identify the specific capabilities required of staff working with people with personality disorders in a range of agencies and delivery settings, and to relate these to the various stages of an individual's career development. The framework is built around identified points of a user pathway. These key points include:

- access and referral routes
- interventions and treatment episodes
- recovery and stepping down from treatment.

The framework looks to staff being able to access training through innovative, multi-disciplinary training courses linked to their career progress. This approach will help to create a workforce with a much better understanding of personality disorders and who are more aware of the impact of these disorders on families, individuals, agencies and the wider society. In turn, the aspiration is that such a workforce will act more appropriately, compassionately and be less judgemental to behaviours that are often hard to understand and difficult to tolerate. This trained workforce should be able to work more confidently with people with a personality disorder in multi-disciplinary teams, delivering increasingly better evidenced interventions and supports. This better trained and more aware workforce will also be able to support and empower those who use services. They will help individuals to achieve their full potential and in so doing break the cycle of rejection which characterises so much of the negative and rejecting attitudes and practices of so many agencies.

The *Personality Disorder Capabilities Framework* describes the qualities and skills required by individuals working in primary, secondary and specialist services and also in the wide range of other community agencies that people may contact. The framework encompasses:

- 'performance'—skills that practitioners need to have and how they need to use them in their work
- 'ethics'—integrating values and social awareness into professional practice

- 'reflective practice'—effectively implementing evidence-based practice and review, and learning from outcomes
- 'commitment to life-long learning'.

The framework is built on the assumption that different staff in different organisations may well need different 'levels' of the same capability, linked to their roles and functions in a given service. To do this, the framework introduces the idea of the 'skills escalator'. This enables the development of valued career pathways in working with people with a personality disorder. It recognises that in common with many other areas of health and social care some of the interaction most valued by service users is undertaken by people with no formal professional qualifications, and indeed by service users themselves. The wide range and complexity of concerns and needs presented by people with personality disorders requires a well co-ordinated multi-disciplinary and multi-skilled approach. Inevitably, some of these staff will work outside the specialist mental health sector, or indeed local authorities and the NHS more generally. These individuals also need an appropriate level of understanding and skills in engaging, communicating with and delivering the services and support of their agencies to people with personality disorders.

The framework also proposes that *managing* teams, and the leadership of organisations providing services to people with personality disorders, is a critical area of capability. In the absence of this leadership capability, there is likely to be a high level of burn-out, absenteeism, sickness and dis-illusionment in teams working with people with personality disorders. The framework outlines the sort of management capabilities required to support staff and sustain services. The framework identifies the capable *organisation* as being key to staff becoming and remaining effective. It defines the capable organisation as being one that requires:

- operational models that can respond to the complexity of the needs presented by service users
- ease of access to appropriate levels of treatment and support
- the development of standards for multi-disciplinary service delivery
- cross-boundary and cross-agency agreements to support the movement of service users away from dependency on services and towards proper social inclusion
- consistent support for staff teams
- access to supervision, education and training.

The framework emphasises that all the above must be underpinned by a culture aimed at sustaining learning. The capable organisational model has

implications for the way learning opportunities are delivered and sustained. The boundary between training, practice development and supervision is not a clear one, and each of these dimensions has a role to play in growing and sustaining the professional development of staff.

Probably the most critical aspect of the framework, which, though harrowing, gives cause for optimism, is the fact that it leans heavily on the experiences of people with personality disorder who are contemporary users of the very variable services currently available. It is designed around the user pathway into, through and out of service. It highlights the staff capabilities needed at identified points on the user pathway and it relates the type and level of training required by different staff if they are to develop those capabilities. The framework emphasises that in order to work positively with people with personality disorders, it is essential to have an understanding of the causes and the consequences of these complex conditions. The debate has been clouded over recent years by the close connection made by many politicians and sections of the media between personality disorder and dangerousness. Whilst there clearly are dangerous people who have personality disorders, the numbers are small. It is much more common for people with personality disorder to be highly vulnerable to abuse and the experience of violence, and to self-harm and suicide. 'We have been damaged, often early in life and we have grown up with mistaken beliefs about ourselves. For these reasons we have difficulties with relationships because we often believe that we are unlovable and we are very sensitive to rejection. For that reason we need easier and known access to services' (quote from a service user in *Personality Disorder*; North Essex News, 2003).

The framework starts from this user viewpoint and identifies four domains of capabilities:

- promoting social functioning and obtaining social support
- improving psychological well-being
- assessing and managing risk to self and others
- management and leadership.

Each of these domains is related to four career stages:

- pre-employment
- vocational education
- professional training
- continuing professional development.

The framework details what expectations there should be of the training and skills required to operate as a capable practitioner at each of the career stages and for each of the domains of capability.

THE SKILLS ESCALATOR

The *Capabilities Framework* builds on the concept of the 'Skills Escalator'. Modern NHS human resource practice is predicated on organisations committing to give people without professional qualifications, or who work at relatively low skill levels in the NHS and other heath and social care settings, the opportunity to progress to roles requiring professional levels of training and qualification. The model of the skills escalator puts in place what are termed 'stepping-on points', cadet schemes, role conversion, back-to-work schemes and 'stepping-off points', to enable existing staff to move progressively on to more demanding and complex roles. The escalator approach opens up opportunities for groups of staff whose developmental needs have been overlooked. It acknowledges that life and experiences from other work settings can be just as valuable as more formal pre-professional training and experience. It enables organisations to draw in people with the right personal attitudes and attributes needed for work within new services, rather than focussing exclusively on their professional or academic achievements. It also offers a way out of career ruts for existing staff. The development of a career escalator for work in personality disorder services opens up the opportunity for a more strategic and integrated approach to workforce recruitment, retention and development. It also encourages innovative approaches to recruitment that are more likely to draw in people with the personal attributes required for work within new services for personality disorder rather than the current focus on professional qualifications.

COMMUNITY MENTAL HEALTH TEAMS AND THE CAPABILITIES FRAMEWORK

What relevance do the new initiatives in services for people with personality disorders have for community mental health teams (CMHTs) and their individual staff members? Is there any relevance to CMHTs of the *Capabilities Framework* and the skills escalator? The answer to both questions is, unequivocally, yes. The reason why, and some of the practical applications, are explored in the remainder of this chapter.

CMHTs are at a crossroads in their development and their role in the delivery of modern mental health services. Since the post-NSFMH