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Exploring Ethnicity and Personality Disorder in a UK Context: A scoping review of the literature

Abstract

Objectives:

The UK Mental Health Act (MHA) Reform (2021) on race and ethnicity promotes new governmental strategies to tackle inequalities faced by ethnically racialised communities detained under the MHA. However, there is a scarcity in Personality Disorder and Ethnicity research. This review aimed to investigate what is available in the United Kingdom (UK) in relation to prevalence, aetiology and treatment provisions of personality disorder for ethnically diverse patients, and to understand their interconnectedness with mental health and criminal justice service provisions. Three key areas of investigations were reviewed, (1) UK prevalence of personality disorder amongst ethnically diverse individuals; (2) Aetiology of personality disorder and ethnicity; (3) Treatment provisions for ethnically diverse individuals diagnosed with personality disorder.

Design:

A scoping study review involved a comprehensive scanning of literature published between 2003 and 2022. Screening and data extraction tools were co-produced by an ethnically diverse research team, including people with lived experience of mental health and occupational expertise. Collaborative work was complete throughout the review, ensuring the research remained valid and reliable.

Results:

Ten papers were included. Results demonstrated an evident gap in the literature. Of these, nine papers discussed their prevalence, three papers informed on treatment provisions, only one

made reference to aetiology. This review further supports the notion that personality disorder is under-represented within ethnic minority populations, particularly of African, Caribbean and British heritage, however the reasons for this are multi-faceted and complex, hence requiring further investigation. The evidence collected relating to treatment provisions of personality disorder was limited and of low quality to reach a clear conclusion on effective treatments for ethnically diverse patients.

Conclusion:

The shortage of findings on prevalence, aetiology and treatment provisions, emphasises the need to prioritise further research in this area. Results provide valuable insights into this limited body of knowledge from a UK perspective.

Keywords: Personality Disorder, Ethnicity, Ethnically Racialised Communities, Black Asian Minority Ethnic (BAME) populations, Adults, United Kingdom, Prevalence, Aetiology, Treatment, Service provision, Mental Health, Criminal Justice.

Introduction

Personality disorder is a contentious diagnostic label in the United Kingdom (UK) and has been a diagnosis that for many has led to exclusion from services with a post code lottery of evidence based psychological treatment provision being made available (Mind 2018; Lamph et al. 2021).

Personality disorder is defined as;

‘an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence

or early adulthood, is stable over time, and leads to distress or impairment.’ (American Psychiatric Association [APA], 2013, P. 645). Personality Disorder service provision has expanded significantly over the past decade in both health and criminal justice settings in the UK. Diversity and ethnicity of the UK population is increasing, which is clearly indicated in the last UK census (ONS 2022). The literature however relating to ethnicity and personality disorder has been under researched.

The last thorough review of the literature relating to ethnicity and personality disorder was conducted over a decade ago (McGilloway et al. 2010). The Adult Psychiatric Morbidity Survey (HM Government, 2014) indicated that personality disorder prevalence in general household populations showed no significant differences between ethnic groups. There appears however to be a disproportionately lower number of ethnically diverse patients in mental health settings who receive a diagnosis of personality disorder, hence they are less likely to receive this diagnosis when compared to white patients. Leese et al. (2006) found that 30% of white patients compared to 3% of ethnically racialised patients received a personality disorder diagnosis in secure settings. Keown, Holloway and Kuipers (2005) found that 62% of white patients were admitted in high secure mental health settings with personality disorder, compared to 33% of black and 25% Asian patients. Kirkbride et al. (2017) identified that people from ethnic minority groups were five times more likely to experience a psychotic disorder than white people in the UK. Whilst it is recognised that more ethnically diverse people to white people are diagnosed with psychotic disorders, the same is not true of people who receive a diagnosis of personality disorder. However, the rationale behind this incidence was unclear, bringing key suggestions about the influences that impact upon the likelihood of being diagnosed with personality disorder, or whether personality disorder symptoms may have possibly been overlooked, misdiagnosed, or untreated in people from ethnic minority groups.

Rationale for the review:

Whilst there is lots of progress in research evidencing the issues of ethnic inequalities and mental health (e.g. Health and mental health statistics - Institute of Race Relations (irr.org.uk) and NHS Health and Race Observatory (nhsrho.org), research around ethnicity and personality disorder is still limited globally (McGilloway et al. 2010). UK service provision is very different to other western countries due to our NHS service and offender personality disorder (OPD) provisions in criminal justice settings; hence we have conducted this very focused review in a UK context to understand prevalence, treatment provision and understanding of aetiology in a focused UK based literature review. The OPD pathway was developed in the UK to ensure that psychologically informed criminal justice services were provided for people with personality disorder to enhance understanding and support rehabilitation, trauma informed, and relational practice based (Skett and Lewis, 2019).

We know that for some racial groups there is a disproportionate use of coercive practice with forced treatment with an over representation in locked facilities and detention, whilst at the same time there is an under-representation in therapeutic programmes and consensual treatment (NIHR 2021). The absence of knowledge and understanding around personality disorder diagnosis and treatment amongst ethnically diverse groups in the UK is pertinent. Documented prevalence of personality disorder amongst this population is limited and little research has been complete in this area (Hossain et al. 2018; NHS Digital 2014). This review takes the first tentative steps to addressing this gap by reviewing the UK literature on personality disorder and ethnicity, focusing on prevalence, aetiology and existing treatments for culturally diverse individuals diagnosed with personality disorder. Following this scoping review, recommendations for future practice and research were made, to address health inequality.

Aim and objectives of this study:

The construct of personality disorder is something that has arisen out a white European culture (Berrios, 1993) hence there is a reasonable question as to whether it makes sense to other cultures (African, Asian etc). The main purpose of this scoping review was to explore UK based literature in relation to personality disorder, to have a clear understanding of its prevalence, aetiology and treatment provisions for ethnically diverse individuals within healthcare settings, and to also identify any crossover with criminal justice service provisions. To achieve this aim, four objectives were identified:

1. To understand the prevalence of personality disorder amongst ethnically diverse populations in the UK.
2. To understand the aetiology of personality disorder amongst people from ethnically racialised populations.
3. To identify treatment provisions for ethnically racialised patients diagnosed with personality disorder.
4. To make recommendations that would inform and guide mental health and criminal justice service provisions on how best to use the knowledge generated from this study.

Considering different terminologies related to ‘ethnic groups’, consistent use of the expression ‘ethnically diverse individuals/patients/clients’ was adopted in this study as was ethnically racialised communities.

The overarching aim of this scoping review was to explore UK based literature around ethnicity and personality disorder to further understand personality disorder and its relationship to ethnicity. The review is concerned with timeframes from 2003-2022 owing to the radical

service investment from 2003 onwards (National Institute of Mental Health in England [NIMHE] 2003), across both mental health and criminal justice service provisions.

Methods

Research Team:

This research was funded by the University of Central Lancashire's LIFE institute pump priming funds. Owing to the specific area of enquiry, an ethnically diverse research team was identified. This included researchers with lived experiences of mental health service from both as patients and practitioners. Experience of both health and criminal justice service provisions were included to and lived experience of personality disorder represented. The diverse make-up of the team was created to ensure inclusivity and diversity essential to adequately addressing the aims and objectives of this research were covered.

Design:

As scoping reviews are generally flexible and usually applied when studying complex health care interventions (Arksey and O'Malley 2005), this was fitting with the chosen methodology in this study, helping to answer a variety of questions without the need to appraise the quality of included papers (Munn et al. 2018; Arksey and O'Malley 2005). Arksey and O'Malley (2005) six-stage framework was used to map out existing literature related to personality disorder and ethnicity, and to identify gaps in this field. As the sixth stage was optional and referred to consultation, this was excluded because the research team highlighted its irrelevance in this research. This process was considered suitable to elude any replication that could potentially affect this review, while meeting this study's aim and objectives.

1. Identifying the research question

Guided by Arksey and O'Malley (2005) suggestions, comprehensive research questions were considered in this scoping review to maximise findings, which could have been limited if the focus was only on a 'highly focussed review question'. This recommendation helped formulate research questions that guided this scoping review, in line with the study aim and objectives:

- What research on personality disorder and ethnicity have been conducted to date in the UK, within health and criminal justice settings?
- What does the literature say about the prevalence of personality disorder in ethnically diverse populations?
- What is known about the aetiology of personality disorder in ethnically diverse population?
- What treatment provision services are currently offered to ethnically diverse patients diagnosed with personality disorder?

This scoping review's interest was exclusively in UK context due to the presence of the uniquely funded National Health Service (NHS) and Criminal Justice funded services, which distinguished UK mental health provisions from other health services in the world.

2. Identifying relevant studies

Inclusion and Exclusion criteria

Inclusion criteria considered UK only published papers relating to personality disorder and ethnicity with a focus on prevalence, aetiology, treatment provisions, and any crossover with the UK criminal justice. There was no attempt to review academic papers on the above mentioned, areas for the wider population, as this study did not have a comparative objective. An inclusion-exclusion criteria table was developed to help identify the selected literature (Table 1).

Table 1: Screening tool.

Areas for Screening	Inclusion	Exclusion
Population	Personality Disorder BAME Ethnicity 18+ Adults (Include Mixed but not under 18 focus)	Other Mental Health Diagnosis Differential Diagnosis White British Focussed CAMHS that are U18 / or U18ys only papers
Concept / Intervention	Studies / Articles with a focus on Ethnicity and Personality Disorder, Service Provision etc. Key Phrases; Prevalence, Treatments, Aetiology / Causes, Service provision	Anything without a focus on ethnicity and personality disorder, or prevalence, treatments and aetiology
Context	Mental Health and Criminal Justice	Anything focussed outside of Mental Health and Criminal Justice Setting
Study Types	Peer reviewed journals, conceptual, or theoretical papers and all types of reviews	Published books and / or book chapters available offline only, PhD / Masters thesis, editorials, conference papers, conference abstracts.
Timescales	2003- 2022	
Language	Published in English only	
Country	Only UK Based	

The identification of literature was achieved by developing and testing out a screening tool (Table 1). While critical appraisal of the quality of included studies was not compulsory in this

scoping review (Armstrong et al. 2011), Levac et al.'s (2010) revised version of Arksey and O'Malley (2005) six-stage framework was however used to assess the quality of included papers, thus meeting Daudt et al.'s (2013) recommendation of using quality assessment in scoping reviews. This screening tool was devised by the core research team. The screening tool aimed to help identify relevant papers from the database search, using Rayyan systematic review tool. Research team calibration meetings took place to pilot the screening tool and changes were made until team consistency in its use was reached. This process enabled the researchers to become familiar with the screening tool and ensured consistency in its application.

Initially, titles and abstracts of selected studies were screened, followed by a thorough screening of full articles to enhance inclusion criteria. Inclusion criteria was limited to publications between 2003 and 2022, with 2003 being chosen due to this being the year personality disorder service received focused attention and increased investment in the UK having previously been seen as a diagnosis for exclusion (NIMHE 2003). All publications included had to relate to a UK context and be written in English.

Search strategy

A systematic approach was used to search a wide range of bibliographic databases covering healthcare, sociology, policy, and criminal justice literature. These included Medline (Ovid), Embase (Ovid), HMIC (Ovid), CINAHL (EBSCOhost), PsycINFO (EBSCOhost), SocINDEX (EBSCOhost), Criminal Justice Abstracts (EBSCOhost), Web of Science. Hand searches of key academic literature and journals were also carried out, as well as hand searching of reference lists, to ensure the inclusion of all relevant publications. The search strategy was based around the topic of personality disorders, and the NICE UK geographic search filter was used to limit the search to UK publications (Ayiku et al. 2017) (see Appendix 1 for an example

search strategy). These terms were jointly agreed upon by the team and influenced by existing knowledge of the area and lived experiences of the research team.

3. Selection of included literature

Arksey and O'Malley (2005) highlight the significance of reducing prejudices during the selection stage of studies. A total of 2125 papers related to personality disorder and ethnicity were initially identified from the initial electronic database searches. Of these, 573 were duplicated and removed before screening. From the remaining 1552 papers screened, 1476 did not meet the initial screening criteria, leaving only 76 papers that went through further screening. Of these, only ten papers were found to be relevant for inclusion, after the full texts were reviewed. A PRISMA diagram (figure 1) was used to provide detailed information related to included studies.

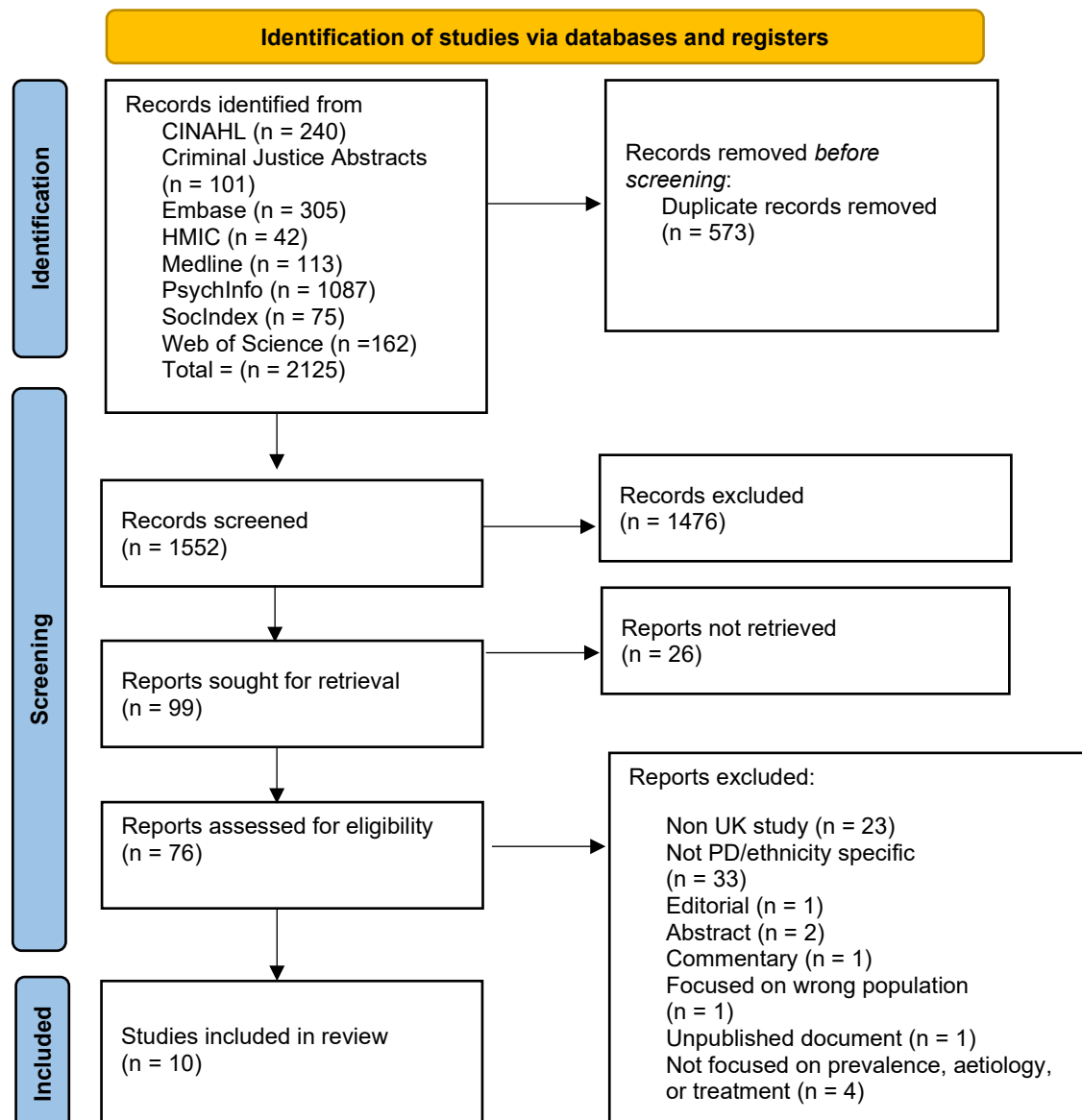


Figure 1: PRISMA Diagram

The selection process was achieved by using the devised screening tool that helped identify the relevant papers included during the search strategy. To enhance rigor to this review, inter-rater reliability (IRR) cut off scores of +80% was set to ensure consistency amongst the different reviewers. Two paired sets of blinded researchers independently and blindly screened 10% of papers identified via the database search at both the title and abstract screening stage (IRR scores of 89.68% (PB and SS) and 98.01% (GL and PM) was achieved) and also full text

screening stage (IRR scores of 83.33% was achieved for both pairs). Upon completing the blind review, paired researchers came together to discuss and work through discrepancies in decisions.

4. *Charting the data*

Comprehensive data were extracted, tabulated and documented by the research team to help capture relevant information in each selected paper, and help answer the research questions of this study. Table 2 provides details of the publications (author, year, title), area specific countries, setting, and those findings that considered the three main objectives (prevalence, aetiology and treatment). Paper ID numbers will be used to identify studies referred to in this review.

Table 2: Data extraction table - Study features

Paper ID	Author, Title and Year	Area Specific Country	Setting	Prevalence	Aetiology	Treatment Provision
1	Crawford et al (2012) The prevalence of personality disorder among ethnic minorities: Findings from a national household survey	England, Scotland and Wales	Health	X	X	
2	McKenzie et al (2019) Assessing needs for psychiatric treatment in prisoners: 3. Comparison of care received by black and minority ethnic prisoners and by white prisoners	London, England	Criminal Justice	X		
3	McGrath et al (2020) Barriers to accessing psychological treatment for medium to high-risk male young offenders	South England	Criminal Justice			X

4	Pereira et al (2005) The London Survey of Psychiatric Intensive Care Units: psychiatric intensive care; patient characteristics and pathways for admission and discharge	London England	Health	X		
5	Raffi et al (2010) Ethnic distribution of personality disorder	Merseyside England	Health	X		
6	Hunter et al (2019) “Give it a Try”: experiences of black, Asian and minority ethnic young men in a prison-based offender personality	Aylesbury England	Criminal Justice	X		
7	Leese et al (2006) Ethnic differences among patients in high-security psychiatric hospitals in England	Ashworth, Broadmoor and Rampton England	Health / Criminal Justice	X		
8	Garrett et al (2011) Personality Disorder: challenges in service development in the light of the new NICE guidelines	London England	Health	X		X
9	Geraghty and Warren (2003) Ethnic diversity and equality of access to specialist therapeutic community treatment for severe personality disorder	Surrey England	Health	X		X
10	Hossain et al (2018) Ethnic variation in personality disorder: evaluation of 6 years of hospital admissions	London England London	Health	X		

Results

5. Collating, Summarising and reporting the results

The ten papers included in this study were conducted in the UK. Out of these, nine made reference to the prevalence of personality disorder, three on treatment provisions, and only one of the studies informed on the aetiology of personality disorder for ethnically diverse patients (Table 2), where crossovers with the UK healthcare settings and criminal justice were investigated.

Objective 1 - Understanding Prevalence

The prevalence of personality disorder for white British, black/mixed and Asian/mixed populations is displayed in Table 3. Of the ten included studies, nine studies reported prevalence data (Crawford et al. 2012; Garrett et al. 2011; Geraghty and Warren 2003; Hossain et al. 2018; Hunter, Craig and Shaw 2019; Leese et al. 2006; McKenzie et al. 2019; Pereira et al. 2005 and Raffi et al. 2010). Five studies presented ethnicity data separately from personality disorder data (Crawford et al. 2012; McKenzie et al. 2019; Pereira et al. 2005; Leese et al. 2006; Hossain et al. 2018) and three studies comprised of samples where all participants were diagnosed with a personality disorder (Garrett et al. 2011; Geraghty and Warren 2003; Raffi et al. 2010). One study used a mean prevalence estimate from a large sample of in-patient admissions (Hossain et al. 2005). The prevalence of a personality disorder from BAME populations ranged from 1.8% (Geraghty and Warren 2003) to 38% (Crawford et al. 2012) across the studies. Health service and criminal justice service settings will be reported separately to identify the differences within and across the different settings.

Health Services

Included health service studies reported a number of inequalities between black and ethnic minority groups in comparison to white British populations in terms of being diagnosed and referred to specialist services.

Two studies (Hossain et al. 2018; Raffi et al. 2010) reported under-diagnosis of personality disorder in black and ethnic minority groups. There was a statistically significant lower prevalence of all ethnicities in these two studies compared with the included white British populations. Raffi et al. (2010) identified that from a population of 273 patients diagnosed with personality disorder only 8.4% were from black and ethnic minority groups compared to 91.6% who were white British. Within a study focusing on the clinical characteristics of patients admitted to Psychiatric Intensive Care Units (Pereira et al. 2005), there was a higher prevalence of personality disorder in white patients compared to black patients (25% vs. 2.2%).

In contrast to these studies, the results of a national household survey (Crawford et al. 2012) report that Personality disorder was as prevalent in people from ethnically racialised communities. However, it should also be noted that the study comprised of a mostly white participants and the authors used a self-reported measure to screen for personality disorder and therefore an overrepresentation of the exact prevalence rates is probable, hence these figures should be treated with some caution.

Two studies (Geraghty and Warren 2003; Garrett et al. 2011) reported that referrals of ethnic minorities to personality disorder services are lower in comparison to white British populations. In a London borough where a third of the population is Bangladeshi only 9% of the Asian population were referred to the service in comparison to 59% white British and the referral of other BAME populations was 10% (Garrett et al. 2011). Similarly, Geraghty and Warren (2003) reported over a 4-year period just over 80% of hospital referrals were white British and

identified that people from ethnic minority backgrounds were also less likely to be offered a selection interview.

Table 3: Study populations Prevalence

Paper ID	Author (Date)	Setting	Sample size	Ethnicity within the sample			Ethnicity with Personality Disorder		
				White	Black/Mixed	Asian/Mixed	White (%)	Black/Mixed (%)	Asian/Mixed (%)
1	Crawford et al (2012)	General public	8351	7886	176	154	2278/7886 (28.9%)	67/176 (38.1%)	54/154 (35.1%)
2	McKenzie et al (2019)	Prison	368	205	163	-	74/205 (36.1%)	52/163 (31.9%)	-
4	Pereira et al (2005)	Psychiatric Intensive Care Unit	176	68	89	-	17/68 (25%)	2/89 (2.2%)	-
5	Raffi et al (2010)*	Mental health provider	273	-	-	-	250/273 (91.6%)	23/273 (8.4%)	-
6	Hunter et al (2019)	OPD Pathway	-	-	-	-	-	26% BAME in prison compared 14% general Population	-
7	Leese et al (2006)	Psychiatric hospital	1081	878	203	-	265/878 (30.2%)	7/203 (3.4%)	-
8	Garrett et al (2011)*	Personality Disorder Service*	100	-	-	-	59/100 (59%)	10/100 (10%)	9/100 (9%)

9	Geraghty and Warren (2003)*	Hospital	792	-	-	-	639/792 (80.7%)	14/792 (1.8%)	4/792(0.5%)
10	Hossain et al (2018)†	Hospital	19102	6374	4856	3366	1090/6374(17%)	226/4856 (4.7%)	172/3366(5.1%)

* all study participants were diagnosed with Personality Disorder. † data derived from a prevalence estimate.

Criminal Justice Services

Within the Prison service one study reported results with regards to the prevalence of personality disorder in black prisoners in comparison to white prisoners (McKenzie et al. 2019). McKenzie and Colleagues (2019) report that 36.1% of white prisoners and 31.9% of ethnically racialised prisoners had personality disorder. Ethnically racialised prisoners were also significantly less likely than white prisoners to have problems associated with personality disorder. Hunter, Craig and Shaw (2019) focussed on the Offender Personality Disorder (OPD) pathway service in Aylesbury England and makes reference to prevalence but this study lacks detail and instead draws comparisons with personality disorder in prison populations and how those from ethnically racialised communities are more highly represented 26% in prison compared 14% general Population.

Leese et al. (2006) focussed upon the prevalence of people with personality disorder from ethnically diverse backgrounds and identified an over-representation of white people compared to black people with personality disorder. However, they also highlight an over-representation of black patients in special hospitals. The over-representation of black patients in special hospitals, in light of the under-representation of those who receive a personality disorder diagnosis, is in itself an interesting finding that corroborates our initial identified concerns

These findings are further corroborated by Hunter, Craig and Shaw (2019) who described high rates of emerging personality disorder in ethnically racialised men in young offender institutions. Ethnic diversities are referred to OPD services proportionately however their engagement with OPD services is reported disproportionality, owing to people from ethnically diverse backgrounds being more likely to decline OPD involvement post referral (Jolliffe et al. 2017). Within the Hunter, Craig and Shaw (2019) study, qualitative interviews with service

users were conducted to understand ethnically racialised community experiences. The findings describe discussions of intersectionality as a barrier to fit in, but it is highlighted that this is not focussed on ethnicity alone, but instead also includes; age, gender, trauma histories, and personality difficulties. Stowell-Smith and McKeown (1999) reported that psychological needs of people from different ethnic backgrounds can be conceptualised in different ways by health care staff which might provide some insight into the under-representations reported within this review.

Objective 2 - Understanding Aetiology

Of the ten included papers only one made reference to understanding aetiology albeit briefly (Crawford et al. 2012). None of the other included papers focussed or provided insights into the aetiology of personality disorder in ethnic minority groups, which highlights that little is understood about ethnicity and personality disorder in a UK context. This is not surprising given the dearth of literature identified in this neglected area of research.

Objective 3 - Understanding Treatment Provisions

There were only three studies that reported data aligned to treatment provisions out of the ten included papers, with McGrath, Shaw and Farquharson (2020) focusing on criminal justice service provision, while Garrett et al. (2011) and Geraghty and Warren (2003) discussed treatment provisions based in health services settings, the former debating on challenges within service development and the latter focussing on therapeutic community service and ethnic diversity.

Treatment provision and Criminal Justice Service

McGrath, Shaw and Farquharson (2020) cross-sectional comparative study reported barriers to accessing psychological treatment in medium to high-risk young offenders' prisons, comparing ethnically racialised young offenders to white young offenders, and scrutinising further engagement and non-engagement in treatment within the two groups. In this study, the ethnically racialised groups were identified as Group 1 (those engaged in psychological treatment) and Group 2 (those not engaged in treatment). Similar divisions were observed for their white counterparts, identified here as Group A and Group B. Young offenders in all groups presented equal levels of psychological needs.

A national screening tool embedded in the Offender Assessment System known as OASys Antisocial Personality Disorder Screen was one of the outcome measures used in this study to screen all participants for pathological personality traits, alongside barriers to accessing treatment in prison (BATP), and Clinical outcomes in routine evaluation outcome measure (CORE-OM).

Group 2 reported significant barriers to accessing treatment in prison, which affected them to a greater extent. They further disclosed treatment stigma barriers when requesting help, possibly leading to their non-engagement in psychological treatment, compared to ethnically racialised treatment Group 1, despite presenting with equal levels of psychological needs in both groups. McGrath, Shaw and Farquharson (2020) reported that ethnically racialised young prisoners were more distrustful to psychological treatments than white offenders. Nevertheless, the authors found no difference between ethnically racialised Group 1 and 2 when exploring the ten most reported and rated barriers to psychological treatment in prison. Amongst cited barriers to treatments, the most common reported responses included: wanting to resolve

problems on their own, a lack of trust, not wanting others to know about their difficulties, stigma barriers, with authors further informing that black youth prisoners were less likely to receive treatment than their white counterparts. However, no significant barriers were acknowledged amongst white young offender groups (engaged and non-engaged in treatment) when accessing treatments in prisons, emphasising the uniqueness of the problem for the ethnically racialised groups of offenders, who faced more barriers to accessing psychological treatment in prisons. Looking at the results of this review collectively however the findings of McGrath, Shaw and Farquharson (2020) are likely to also apply to health care settings and the ethnically racialised challenges across the whole system.

This study may contribute to inform the UK public health and mental health service provisions in criminal justice settings, having helped increase understanding of the barriers to accessing psychological treatment for ethnically racialised young men in prison. Furthermore, it demonstrated that negative attitudes relating to psychological treatment and environmental barriers can hinder access to evidence based psychological treatments for ethnically racialised male young offenders. However, the self-report methodology used by the authors (BATP and CORE-OM measures) may have been biased, a common limitation of all self-report measures (Chentsova and Lyons 2021) that should be considered, mainly when using prisoners as participants in criminal justice research.

Furthermore, McGrath, Shaw and Farquharson (2020) were unable to differentiate between newly occurring and long-established treatment conditions, or to conclude their causality, a limitation of cross-sectional study design (Wang and Cheng 2020), leading to question its full effectiveness in investigating treatments related to personality disorder and ethnicity. For example, the average CORE-OM score fell in the ‘mild range’ despite clear indications of high levels of psychological distress, with 50% of participants living on the vulnerable prisoner wing taking prescribed medication for mood difficulties, or being on an “Assessment, Care in

Custody and Teamwork” (ACCT) plan. More sensitive measures other than the CORE-OM score could have for example been considered for this population who could fear the impact of their contribution in criminal justice research. This may be suggested for future studies, to increase cooperation and trust when they shared their thoughts and feelings.

The sample in this study was further limited, as little was known in regard with participants’ treatment history, or the length of their sentence in prison, which could have influenced the findings, although homogeneity in terms of age, risk level and gender was recorded.

Treatment provision and health service

Garrett et al. (2011) case record study discussed the availability of a health service for people with severe and moderate personality disorders. Authors used a case vignette approach to investigate treatment programmes offered to individuals screened with borderline personality disorder (BPD), such as Group-based therapy with different levels of intensity; a mentalisation-based treatment approach, which is evidence-based model for BPD; and NICE guidelines (NICE 2009a) used as a framework. However, the authors did not use standardised tools to measure outcomes in this study, instead developing their own forms to capture relevant data, which included previous diagnosis, medication and previous treatment. Nevertheless, the Global Assessment Functioning scores was used alongside the form as another tool in this study.

Garrett et al. (2011) further reported the use of psychotropic medication treatments for BPD by 30 out of 48 individuals diagnosed with BPD, from which 23% of participants being prescribed at least 3 differing medications, the most frequently used being antidepressants (53% of patients), and antipsychotics (36%). However, this paper provided very little information to be related to ethnically diverse populations. The case vignette included was a typical case of a

white British patient, with a hypothetical justification of the low prevalence provided. The personality disorder service referral population did not clearly reflect ethnic groups, while the geographical environment was known to be ethnically diverse, with a third of the borough being of Bangladeshi origin. Only 9% of this group was recorded in the referral population, and other ethnic groups recorded between 2% and 1%. This case study demonstrated the scarcity in services for ethnically diverse populations in regard to personality disorder, considering the low number of referrals for ethnically diverse individuals to personality disorder services compared to their white counterparts, in an area known to have a high prevalence of ethnic minoritized groups.

Geraghty and Warren (2003) study examined records from Henderson Hospital between 1996-2000 to ascertain whether ethnic minorities show a different pattern of exit from the process than people from other backgrounds. Authors suggested that therapeutic community treatment was appropriate for clients from minority ethnic backgrounds. Equality of access to people from minority ethnic groups, as well as psychotherapy services as interventions for ethnic minority clients with severe personality disorders were promoted in this article.

This study reported that therapeutic interventions have been introduced for minority ethnic groups in Henderson hospital, referring to the provision of specialist treatment. However, this population was still under-represented in the hospital over time. There was still a lack of clarity as of what type of interventions have been introduced for minority ethnic groups, outcome measures were missing to evaluate their effectiveness and to justify the low prevalence of ethnic minority clients in the service twelve years later, particularly when the Henderson hospital is considered culturally adapted with a suitable treatment service for ethnic minority clients and inclusive, with staff from minority ethnic groups represented in the service.

Discussion

Through this research we made some early steps towards addressing a gap in knowledge and provide an insight and exploration of the literature pertaining to personality disorder and ethnicity in a UK specific context, with a focus on what is known about prevalence, aetiology and treatment provisions.

This review discovered that there is much to know and explore and that the literature and understanding in this area has been neglected, established through the dearth of literature identified. There is a need for a research focus in Personality Disorder and Ethnicity to add to existing knowledge, understand the differences in prevalence, increase understanding of aetiology, and enhance treatment provisions for ethnically diverse populations in the UK.

Personality disorder for some is still described as a diagnosis of exclusion despite emphasis, funding and attention being placed on this since the introduction of NIHME (2003), and more recently in the Royal College of Psychiatrist Position Statement (Royal College of Psychiatrists 2020).

Despite almost two decades on awareness training and education investments which is still ongoing and whilst progress is reported, many believe this has not had the impact it was anticipated to have had, particularly in regard with personality disorder, ethnicity and race which has been highlighted as a key area in the redevelopment of existing national personality training programmes (Baldwin et al. 2019).

Of further concerns, failure to receive a diagnosis of personality disorder may lead to inaccessibility of service provisions for ethnically diverse individuals, who become excluded from accessing the growing evidenced based psychological therapies for people with diagnoses

of personality disorder that people of white origin are benefiting, such as Dialectical Behavioural Therapy (DBT), Mentalisation Based Therapy (MBT) and Schema Therapy (Stoffers et al. 2012). There are also Nice Guidelines (NICE, 2009a) for BPD and ASPD (NICE 2009b) which highlight and provide guidance around evidence-based treatments for these conditions, however whilst evidence based interventions are available in many areas, a postcode lottery of service provision in the UK is described (Mind, 2018).

We have much to learn and whilst this review scopes out what we do not know, it does highlight evidence of the gaps in the literature and our understanding of ethnicity and personality disorder across both mental health and the criminal justice research community in the UK.

What have we learnt about prevalence?

Prevalence interestingly in criminal justice populations is reported to be higher for people from ethnically racialised communities with Hunter, Craig and Shaw (2019) identifying those from ethnically racialised communities are incarcerated at higher rates than that of the general population. Whilst McKenzie et al. (2019) states lower overall percentage of prisoners from ethnically racialised communities, this is not representative of the UK general population and hence there is still proportionately higher prevalence of ethnically racialised communities in prison.

The development of the OPD pathway however that identifies people with personality related difficulties using the OAYsis screening tool still seems to pay very little attention to the issues of diversity and the most recent practitioner guidance.

There is some reference in the newest practitioner guidance (Craissati, Joseph and Skett 2020) that talks about being brave, courageous when talking about ethnicity and cultural difference. It also highlights unconscious bias and higher prevalence of contacts with black men in

criminal justice settings. But the limited guidance or solutions for addressing this is a further indication of the need for further focus and interrogation in this area.

Findings suggest we need to explore why our services seem inaccessible to people from ethnically racialised communities and there is a need to understand this.

Our workforces require further training and education about cultural diversities and sensitivities and the workforce configuration requires a rebalancing. Within personality disorder services it could be argued there is a need to adopt a greater representation of ethnically racialised communities working within the services to make them more accessible. Currently in healthcare settings however that are focussed upon supporting and working with people with personality disorder ethnicity and ethnic diversity is under-represented.

The conflict reported in Crawford et al. (2012) relating to equal prevalence in general populations but under representation in services in a UK context is very important to reflect upon and in informing future recommendations for practice. However, an explanation may be that this general population sample may be indicative of people with personality difficulties being under diagnosed by services, which could be attributed to a number of factors. It is argued within this study that ‘cluster A’ personality disorder (including paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder) are more prevalent in ethnically racialised communities than white populations. It is alluded to that this may be owing to the fact people from ethnically racialised backgrounds are more likely to be living in urban areas and we know other studies report increased personality disorder in those areas, and it is suggested they have increased reported paranoia that could be attributed to and representative of experiences of discrimination and other adversities. Crawford et al. (2012) suggest that it is important to equip staff with essential training to better support cultural awareness, promote diversity and enhance the sensitivity of services making them more

accessible to diverse populations. It is suggested that an inherent cultural bias may be responsible for the under reported prevalence of personality disorder in mental health services.

Personality disorder diagnosis of ethnic minority groups was identified to be much lower than that of white, which could mean that they are misdiagnosed with other diagnoses, do not access services, owing to a lack of accessibility to ethnically diverse populations, or are missed, hence resulting in people from ethnically diverse backgrounds missing opportunities for evidence-based interventions and support. A lack of cultural insight and knowledge may also be present and require further exploration. Maybe this provides a rationale for why people are not identified with personality disorder from ethnically diverse groups. It could also be argued that why would an already disadvantaged population want to add to that with the diagnosis of probably the most stigmatised, misunderstood and excluded of all mental health diagnosis (Mind, 2018), but in counter argument people from ethnic backgrounds are more likely to be diagnosed with psychotic illness and use of the Mental health Act applied (Gajwani et al. 2016).

The findings of this review further highlight the need to understand the under-representation of personality disorder in people from ethnically racialised communities. Exploration and understanding of why this under-representation is occurring, is required. Could it be that this under-representation is due to aetiological reasons that reduce this risk or is it that people from ethnically racialised communities are more likely to receive other mental health diagnosis. Alternatively could it be that unconscious bias is influencing diagnostic decision making, hence is there a workforce training need requirement not only around personality disorder specifically but also in understanding diversity and different cultures.

Equally whilst overlapping with our exploration of treatment, are our services inaccessible to marginalised groups within society and is the under representation of ethnically racialised

community health care professionals and criminal justice workers a barrier to accessibility and what are we doing to address this.

The ideas of peer support is also something that requires attention, peer support in mental health services is increasingly being utilised to make service provision more accessible, sensitive and to improve and enhance inclusivity and hope. However questions are raised as to whether the same investment or consideration of ethnic diversity is being included within those developments (Shalaby and Agyapong 2020), despite there being a need to make services more inclusive and representative of the populations they serve.

Additionally increased engagement with families and service users is deemed important to understand sensitivity of diagnosis, terminology that may hinder access and in the development of culturally sensitive friendly environments. Adopting ethnically racialised community role model stories has been suggested (Hunter, Craig and Shaw 2019). However, Hunter, Craig and Shaw (2019) highlighting that these solutions had a very small sample of participant views, and no Asian inclusion was included within this insightful qualitative study. This limitation highlights the need for further research to understand and explore wider views of ethnically racialised community voices in relation to accessibility of services, a non-ethnically racialised community comparator would also have been useful. Whilst it is reported that OPD services representation is comparative, it is under used by people from ethnically racialised communities when compared to white counterparts, owing to less ethnically diverse engagement with OPD services.

Whilst our aim via this review was to further understand prevalence amongst those with personality disorder and from ethnically diverse backgrounds, our analysis whilst providing some reinforcement of the under-representation, it does not provide any conclusive

understanding to the complexity and multi-faceted possible reasons for these findings. It does however highlight the need for furthermore in-depth analysis for this overlooked area.

What have we learnt about Aetiology?

Through this review we have discovered not surprisingly that very little has been written or researched in respect of aetiology of personality disorder in ethnically diverse groups. This is unsurprising owing to the clear lack of attention in this area, the under representation of people from ethnically diverse backgrounds in relation to personality disorder and the challenges we have discovered in the under representation and barriers to engagement in treatment provisions. Leading to the conclusion of how aetiology can be understood when the basic recognition and treatment needs of this group of people are under researched and misunderstood. Despite this however there is a need to understand the aetiology of personality disorder in people from ethnical diverse backgrounds with important explorations into the cultural, community, social experiences and ethnic differences.

What have we learnt about treatment Provisions?

This scoping review investigated treatment provisions for ethnically diverse patients affected by Personality Disorder in UK mental health services and criminal justice system. However, the three identified papers clearly demonstrate a dearth of literature on treatment provision of PD for ethnically diverse individuals in the UK, signifying the need to address current assessment, treatment and management processes that are equitable.

McGrath, Shaw and Farquharson (2020) highlight that young offender males within prison have higher rates of psychological need but do not engage with prison services. Authors have made a good attempt to address an under-researched concern of personality disorder treatment, balancing race representation and an attempt to look at race non-compliance and compliance amongst black young people in the criminal justice system. The authors further offer a good

discussion around past research in this field, exploring their limitations, methodological approaches, clinical implications, measurement tools used and how they justify barriers in accessing personality disorder treatment. However, this study is limited in terms of race, diagnosis, clinical interventions and the pathology of black men, having not examined the impact of racialised white European services that may lead to an inductive approach, with a focus on stigma, district and ethnicity, in the American context. Questioning models of investigation based on race, Pathological Personality trait, particularly the interpretative framework to scoring, would have strengthened this study, as there is a clear lack of focus on ethnic diverse population. The scoring system hides several crucial political issues, evidencing the lack of credibility in the current treatment and therapies in responding to the trauma experienced by black men in the criminal justice system.

Garrett et al. (2011) demonstrate the scarcity of therapeutic health services in regard with severe and moderate personality disorders, in an area with high prevalence of ethnically diverse population. The central limitations of this study are the absolute use of NICE as a value racialised approach to personality disorder, limitations of Community Mental Health Team (CMHT) in addressing race equality part of assessment and treatment processes, and how lived experience is used in relation to the commissioning process. The lack of personality disorder diagnosis within the Bangladeshi community suggests more work is needed to understand and work with the community. Sadly, the paper is unable to demonstrate, explain, analyse or name the challenges for racism within the referral process. It neglects the importance of community demographics, particularly people of a Bangladeshi origin may be subjected to a range of institutional and practice concerns.

Geraghty and Warren (2003) acknowledge and attempt to address the issue regarding the lack of black people being diagnosed with personality disorder and being selected into therapeutic community treatment programmes. However, this study suggests that therapeutic community

treatment is appropriate for clients from minority ethnic backgrounds, despite them being an under-represented population compared to white patients accessing and engaging in specialist psychotherapy services, while being over-represented in psychiatric service provisions. The meaning of black and ethnic minority in this study is unclear, having riskily put all racial groups into one category, which led to the loss of identities and sensitivities within each group. Authors present a pathological approach reinforced by a racially inductive model of research, which assumes the terms, as opposed to the lived experience definition of race and access to services. Whilst there is no significant correlation in clinical factors race, symptomology and criminal histories, these terms deflect the importance of institutional racialised factors, such as the pathology of race. Consequently, authors have missed the opportunity to identify specific needs of the different ethnic groups, which further impacts service and treatment provisions. The above evidence limits the credibility of this study in regard with treatment provision, and further investigation is needed in this field to have a broader understanding of the specialist treatment delivered in the centre, and their effectiveness for ethnic minority patients who are admitted. As an example, Johnstone et al. (2018) have challenged traditional diagnosis by using the Power Threat Meaning Framework (PTMF), adopting a more individualised and psychologically informed approach to understanding mental health challenges and explore what has happened to the person rather than what is wrong with them. This model is known to understand life challenges and subsequent presentations of mental ill health, and hence might be more attentive to the experiences of people from ethnically racialised communities, hence this model may be deemed acceptable to support treatment interventions for people from ethnically diverse backgrounds.

It is important to highlight that psychological outcome measures used in these three studies were heterogeneous, exploring treatment under different clinical lenses. McGrath, Shaw and Farquharson (2020) focused on measuring outcomes for barriers to treatment. Garrett et al.

(2011) measured the impact of psychotropic medication, while Geraghty and Warren (2003) focused on the provision of therapeutic community treatments. None of the three studies were purely treatment orientated, neither discussed any particular psychological interventions to care for ethnically diverse population diagnosed with personality disorder. Likewise, the literature reviewed did not refer to any previous studies which focused solely on personality disorder therapeutic interventions for ethnically diverse patients of any age group, gender, or any environmental setting. Although these three studies highlighted that ethnically diverse patients who took part in their respective research were diagnosed with personality disorder, their recommendations for adapted psychological interventions were limited, although Geraghty and Warren (2003) suggested therapeutic community intervention.

However, as these were the only UK studies included in this review that reported on personality disorder treatments and ethnicity, and in the absence of clear data from the above literature, it is therefore difficult to draw any firm conclusion on the treatment results of this scoping review, showing a significant lack of evidence relating to personality disorder treatments for ethnically diverse individuals in UK criminal justice and health settings. Such limitations stress the need to further investigate appropriate therapeutic interventions for ethnically diverse patients diagnosed with personality disorder, in both health and criminal justice settings in UK.

Limitations:

A key limitation of this study is the UK context in which we focussed, as it could be argued that internationally there are other sources of literature that could have informed this review, however owing to the differences in service provisions internationally not least the UK NHS healthcare system and unique OPD Pathway in criminal justice settings, our aim was to understand specifically the UK context and hence believe this is justified. Additionally, we could have focussed this paper on one setting healthcare or criminal justice, but we felt that the

lack of literature across the sectors available to us that by combining a review of the two settings and drawing comparisons does provide useful insights, However we do recognise that different diagnosis are likely to be focussed upon with healthcare focus upon BPD and Criminal Justice predominately ASPD. Both of which have very different treatment guidelines

Conclusions:

This scoping review provides a timely contribution to the literature that spotlights an under researched and overlooked area of practice and understanding. Whilst it is acknowledged amongst the scientific and clinical communities working within personality disorder that prevalence and the under representation is acknowledged and that there is a lack of specialist treatments, service provisions or understanding of best culturally sensitive practice for supporting ethnically racialised communities with personality disorder. We hope highlighting the deficit in knowledge, research and understanding will be the catalyst for future dedication attention and investment that will potentially inform policy, understanding and training provision of the future. Our aim was to understand this complex area further but ultimately what we have achieved is that this area of mental health and criminal justice practice is neglected. Attention and a greater understanding of what we know about ethnicity and Personality disorder is very much required in the UK today.

This study further highlights that the prevalence of personality disorder in ethnically racialised communities are under-represented. The reasons for this are complex and multi-faceted hence further investigation is required.

Treatment provision lacks any focus on providing culturally sensitive or accessible provisions. The included literature analysed in this review was limited and of low quality making any clear

conclusions on effective treatments for ethnically diverse groups who are diagnosed with personality disorder difficult to reach. Workforce awareness, training and accessibility of service provisions requires active attention from research, practice and commissioner perspectives. The cultural diversity of service provision and engagement of people from ethnically diverse populations in developing and supporting the provision of services require attention.

A greater understanding of the aetiology and causative factors of personality disorder in ethnically diverse populations also requires attention and increased understanding as does the disproportionate use of the MHA and higher rates of psychosis type diagnosis.

Word count 7650

References:

- Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*. 2005;8(1):19-32.
- Ayiku, L., P. Levay, T Hudson, J. Craven, E. Barrett, A. Finnegan, and R. Adams. 2017. The medline UK filter: development and validation of a geographic search filter to retrieve research about the UK from OVID medline. *Health information and libraries journal*, 34(3), 200–216.
- Berrios G, E. (1993) European views on personality disorders: a conceptual history. *Comprehensive Psychiatry*. 34 (1) :14-30. doi: 10.1016/0010-440x(93)90031-x. PMID: 8425387.

Baldwin, V., J. Blazdell, N. S. Gordon, and F. Gordon. 2019. *KUF Scoping Review – A Review of the National Personality Disorder Knowledge and Understanding Framework*, Ministry of Justice.

Chentsova Dutton, Y. .E. and S. H. Lyons, 2021. *Chapter 29 - Different ways of measuring emotions cross-culturally*. Editor(s): Herbert L. Meiselman. *Emotion Measurement (Second Edition)*, Woodhead Publishing, Pages 937-974. ISBN 9780128211250. <https://doi.org/10.1016/B978-0-12-821124-3.00029-6>.

Craissati, J., N. Joseph, and S. Skett. 2020. *Working with People in the Criminal Justice System Showing Personality Difficulties*, 3rd ed., Department of Health/Ministry of Justice, London.

Crawford, M. J., T. Rushwaya, P. Bajaj, P. Tyrer and M. Yang. 2012. "The prevalence of personality disorder among ethnic minorities: Findings from a national household survey." *Personality and Mental Health*. 6 (3).

Department of Health (2009) *Recognising Complexity: Commissioning Guidance for Personality Disorder Services*. London: DH. tinyurl.com/GuidancePersonalityDisorder.

Gajwani, R., H. Parsons, M. Birchwood, and S. P. Singh. 2016 Ethnicity and detention: are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007 *Soc Psychiatry Psychiatr Epidemiol*. 51 703-711. DOI 10.1007/s00127-016-1181-z

Garrett, C., T., S. Lee, L. Blackburn, L. Priestly and K. Bhui. 2011. "Personality disorder: Challenges in service development in the light of the new NICE guidelines." *The Psychiatrist*. 35 (1).

Geraghty, R. and F. Warren 2003. "Ethnic diversity and equality of access to specialist therapeutic community treatment for severe personality disorder." *Psychiatric Bulletin*. 27 (12).

HM Government (2014) Adult Psychiatric Morbidity Survey [Personality disorders - GOV.UK Ethnicity facts and figures \(ethnicity-facts-figures.service.gov.uk\)](https://www.ethnicity-facts-figures.service.gov.uk/)

Hossain, A., M., T. L. Malkov, and K. Bhui. 2018. "Ethnic variation in personality disorder: Evaluation of 6 years of hospital admissions." *BJPsych Bulletin*. 42 (4) 157-161. doi:10.1192/bjb.2018.31

Hunter, S., E. Craig and J. Shaw 2019. "'Give it a Try': Experiences of Black, Asian and minority ethnic young men in a prison-based offender personality disorder service." *Journal of Forensic Practice*. 21(1).

Johnstone, L., M. Boyle, J. Cromby, J. Dillon, D. Harper, P. Kinderman, E. Longden, D. Pilgrim, and J Read, J. 2018. The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. *British Psychological Society*. https://cms.bps.org.uk/sites/default/files/2022-07/PTM%20Framework%20%28January%202018%29_0.pdf

Jolliffe, D., J. Cattell, A. Raza, and P. Minoudis, 2017. "Factors associated with progression in the London pathway project", *Criminal Behaviour and Mental Health*. Vol. 27 No. 3, pp. 222-37, doi: 10.1002/cbm.2035.

Keown P., F. Holloway, and E. Kuipers. 2005. The impact of severe mental illness, co-morbid personality disorders and demographic factors on psychiatric bed use. *Soc Psychiatry Psychiatr Epidemiol*. 40 (1) 42-9.

Kirkbride, J. B., Y. Hameed, K. Ioannidis, G. Ankireddypalli, C. M. Crane, M. Nasir, M. N. Kabacs, A. Metstasio, O. Jenkins, A. Espandian. 2017. Ethnic Minority Status, Age at Immigration and Psychosis Risk in Rural Environments: Evidence from the SEPEA Study. *Schizophrenia Bulletin*. 43 (6) pp1251-1261 <https://doi.org/10.1093/schbul/sbx010>

Lamph G., J. Dorothy, T. Jeynes, A. Coak, A. Elliott, R. Jassat, M. McKeown, and T. Thornton. 2021. A qualitative exploration of the label of personality disorder from the perspectives of people with lived experience and occupational experience. *Mental Health Review Journal*. <https://doi.org/10.1108/MHRJ-05-2020-0035>

Leese, M., G., J. Thornicroft, S. Shaw, R. Thomas, M. A. H. Mohan, and M. Dolan. 2006. "Ethnic differences among patients in high-security psychiatric hospitals in England." *The British Journal of Psychiatry* 188(4).

Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. *Implementation Science*. 2010;5(1):69.

Livesley, J. W. 2021. why is an evidence-based classification of personality disorder so elusive? *Personality and Mental Health*. 15 (8) 8-25. DOI 10.1002/pmh.1471

McGilloway, A., R. E. Hall, T. Lee, K. S. Bhui. 2010. A systematic review of personality disorder, race and ethnicity: prevalence, aetiology and treatment. *BMC Psychiatry*. 10, 33 (2010). <https://doi.org/10.1186/1471-244X-10-33>

McGrath, K., J. Shaw and L. Farquharson. 2020. "Barriers to accessing psychological treatment for medium to high risk male young offenders." *Journal of Forensic Psychiatry and Psychology*. 31(4).

McKenzie, N., H., S Killaspy, S. Jakobowitz, H. Faranak and P. Bebbington. 2019. "Assessing needs for psychiatric treatment in prisoners: 3 Comparison of care received by

black and minority ethnic prisoners and by white prisoners." *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*. 54(7).

Mind. 2018. "*Shining lights in dark corners of people's lives; the consensus statement for people with complex mental health difficulties who are diagnosed with a personality disorder*", available at:

https://www.centreformentalhealth.org.uk/sites/default/files/consensus-statement-final_0.pdf

Munn, Z., M. Peters, C. Stern, C. Tufanaru, A. McArthur, and E Aromataris. 2018. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC medical research methodology*. 18(1), 143. <https://doi.org/10.1186/s12874-018-0611-x>

National institute for Health and Clinical Excellence (NICE). 2009. *Borderline personality disorder: treatment and management*. www.nice.org.uk

National Institute for Mental Health in England. 2003. *Personality Disorder: No longer a diagnosis of exclusion, policy implementation guidance for the development of services for people with personality disorder*. NIMHE: London.

National Institute for Health Research. 2021. *New research to improve experiences of people with serious mental health problems*.

NHS Digital. 2014. *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England*. <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014>

National Institute for Health and Clinical Excellence (NICE)

(2009a) Borderline Personality Disorder: Treatment and Management. www.nice.org.uk.

National Institute for Health and Clinical Excellence (NICE)

(2009b) Anti-Social Personality Disorder: Treatment, Management and Prevention.

www.nice.org.uk.

Office for National Statistic (2011) <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest>

Pearce, S., and R. Haigh, R. 2008. Mini therapeutic communities--A new development in the United Kingdom. *Therapeutic Communities*. 29(2), 111–124.

Pereira, S. M., M. Sarsarn, K. Bhui and C. Paton. 2005. "The London Survey of Psychiatric Intensive Care Units: Psychiatric intensive care; patient characteristics and pathways for admission and discharge." *Journal of Psychiatric Intensive Care*. 1(1).

Raffi, A. and A. Malik. 2010. "Ethnic distribution of personality disorder." *Psychiatrist*. 34 (1).

Royal College of Psychiatrists. 2020., “*PS01/20: services for people diagnosed with personality disorder*”, available at: www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/

Shalaby R, A, H., and V. I. O. Agyapong. 2020. Peer Support in Mental Health: Literature Review *JMIR Ment Health*. 7 (6) doi: [10.2196/15572](https://doi.org/10.2196/15572)

Skett, S., & Lewis, C. (2019). Development of the Offender Personality Disorder Pathway: A summary of the underpinning evidence. *Probation Journal*, 66(2), 167–180. <https://doi.org/10.1177/0264550519832370>

Stoffers, J. M., B. A. Vollm, G. Rucker, A. Timmer, N. Huband, N., and K. Lieb,. 2012. Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*. 8, CD005652.

Stowell-Smith, M. and M. McKeown. 1999, "Race, psychopathy and the self: a discourse analytic study", *British Journal of Medical Psychology*. Vol. 72 No. 4, pp. 459-70, available at: <http://dx.doi.org/10.1348/000711299160176>

Wang, X., and Z. Cheng. 2020.. Cross-sectional studies: strengths, weaknesses, and recommendations. *Chest*. 158(1), S65–S71. Wang and Cheng, 2020

Appendix 1: Search Strategy

(exp Personality Disorders/) OR (personalit* adj3 disorder*) AND (Ethnic Groups/) OR (Race Factors/) OR (ethnic* or bame or bme or race or racial* or minorit*).tw.) OR (south asian* or Black British or afro caribbean or african caribbean or afrocibbean or bangladeshi* or bengali* or indian* or chinese or pakistani* or african* or gyps* or irish traveller* or roma or arab* or Jew* or mixed race or mixed racial* or refugee* or migrant* or immigrant* or asylum seeker*) AND (exp United Kingdom/) OR (national health service* or nhs*) OR (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab.) OR (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in.) OR (bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or

"truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in.) OR (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in.) OR (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in.) OR (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's") NOT (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp australia/ or exp oceania/) not (exp United Kingdom/ or europe/) AND (limit 20 to (english language and yr="2003 -Current"))