Surrey and Borders Partnership NHS
NHS Foundation Trust

PERSONALITY DISORDER STRATEGY
Working Age Adults

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For a better life

Acknowledgement*

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Version Control

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Contents

PERSONALITY DISORDERS STRATEGY

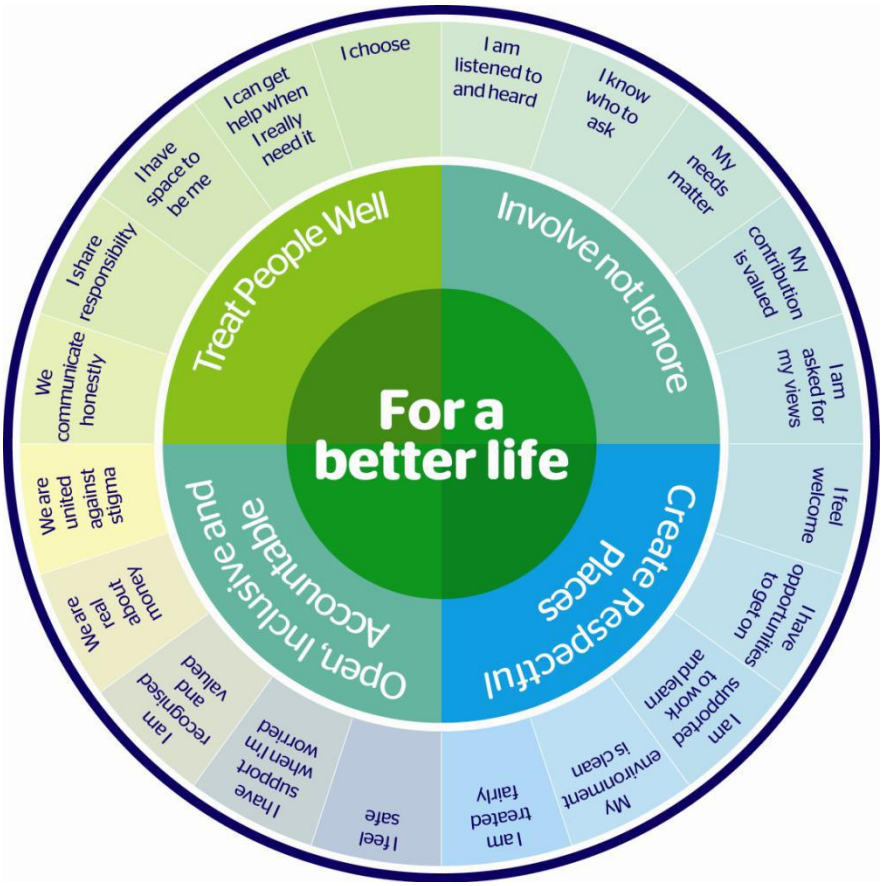
This strategy provides an outline of our approach to working with people with personality disorders, their carers and families. It has been developed through consultation with people using our services, clinical staff and a range of external partners.

1. Our Vision for Health and Care Services

Our core purpose is to work with people and lead communities in improving their mental and physical wellbeing for a better life; through delivering excellent and responsive prevention, diagnosis, early intervention, treatment and care.

2. Our Values

Our values describe how we want people to experience us. They are designed to safeguard our practice and help us maintain a course of empathic support, accountability and continuous improvement.



Our values are at the heart of this strategy and emphasise our passion for people and our respect for their equality and human rights. No person using

our services will be excluded because of having a diagnosis of personality disorder.

3. Principle Underpinning this Strategy

We believe that people with personality disorders can find new ways to improve their health and wellbeing and fulfil their potential as active and equal citizens. Our focus is on recovery and empowering people to live meaningful lives with or without on-going symptoms of their condition. We aim to:

- Create and sustain a culture of hopefulness that is focused on the pursuit of personal goals and ambitions;
- Support people to take responsibility and maintain a sense of control over their own lives and healthcare needs;
- Open up opportunities for people with personality disorders to build a positive identity and a life beyond illness.

This strategy sets out to ensure that people with personality disorders who use our services and their families are able to access high quality care in a timely way and within a kind and respectful environment.

4. Understanding Personality Disorders

4.1. Background

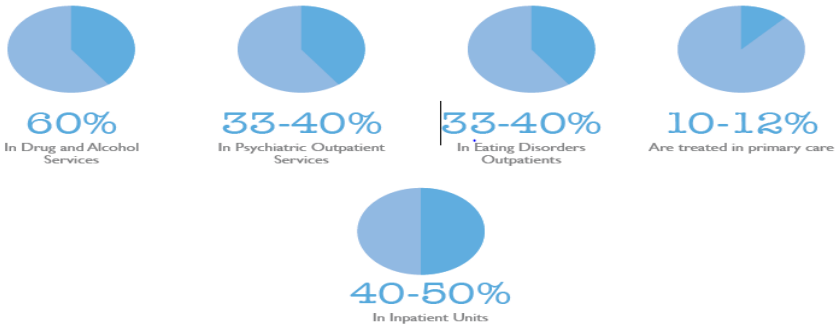
Biology, temperament and quality of care in the early years of life can all influence lifetime wellbeing. We know that growing up in an emotionally secure family with care-givers who are responsive to their children's needs can promote wellbeing, whereas being carried in the womb of a chronically (dis)stressed mother and then being born in the midst of family conflict and poor care can mean children miss out on the benefits of a protective and secure attachment relationship. This in turn can affect the basic building blocks for healthy cognitive, emotional and social development. For some children these experiences negatively influence the way they think about themselves and over time can lead to the development of unhelpful and self-destructive relationship patterns. If this situation continues unchecked it can manifest as personality disorder and may even pass across the generations from parent to child.

Personality disorders are known to emerge in adolescence and continue through into adulthood. People experience significant and ongoing difficulties in their personal, social and occupational functioning which can be highly distressing and stigmatising for all involved. Personality disorders are characterized by longstanding patterns of difficulty across multiple domains of functioning, including cognition (e.g. unusual perceptual experiences, disruptions in the experience of self), emotion (e.g., excessive reactivity or intensity), interpersonal behaviour (e.g., social isolation, high-conflict relationships), and difficulties with impulse control (e.g., repeated engagement in high risk activities). Personality disorder is also associated with poorer long-term physical health outcomes, such as cardiovascular disease, poor nutrition

and reduced life expectancy, as well as increased care costs due to frequent attendance at GP surgeries, accident and emergency departments and acute mental health hospital admissions.

4.2. Prevalence

UK prevalence rates in the general population vary due to poor diagnostic reliability but it has been estimated that as many as 1 in 20 people (5%) will have a personality disorder. Amongst people accessing clinical services, estimates suggest that between 30-40% of people attending secondary care mental health community services and 40-50% of those in inpatient services will have a personality disorder (Coid, et al 2006). Prevalence rates in other clinical settings are described below:



4.3 Personality Disorder Diagnosis

We know that early identification and signposting to appropriate services can help people with personality disorders and their families to improve their health and wellbeing. There are two classification systems that are used to make the diagnosis of Personality Disorder (International Classification of Diseases-ICD and the Diagnostic and Statistical Manual-DSM) and these can be supported by a range of measures and structured interview tools. Broadly speaking, Personality Disorders can be broken down into 3 clusters:

CLUSTER A Odd Eccentric behaviour Bizarre thoughts Socially awkward	CLUSTER B Emotional Erratic Dramatic Relationship Struggles	CLUSTER C Anxious Fearful
Paranoid: Suspicious, distrustful and bears grudges	**Antisocial:** Disregard of other people's rights, lack of remorse, reckless and easily frustrated	**Avoidant:** Sensitive to rejection, low self-esteem and socially inhibited
Schizoid: Detached and prefers isolation	**Borderline:** Mood swings, identity confusion, unstable, intense relationships and impulsive	**Dependent:** Needs others to look after them and lacks self-confidence
Schizotypal: Strange beliefs, poor social skills and eccentric	**Histrionic:** Needs to be noticed, seeks attention and is dramatic	**Obsessive Compulsive/Anankastic:** Controlling, perfectionistic, rigid and preoccupied with detail
	Narcissistic: Has a sense of entitlement, can feel superior to others, and shows disregard and contempt for others	

Personality disorder is a broad term that covers many different presentations. We recognise that diagnosis does not give a perfect representation of the difficulties and needs a person experiences and it is not always a straightforward process. A high percentage of individuals diagnosed with one personality disorder can meet the criteria for another and can have additional mental and physical health problems that will need appropriate assessment and treatment (e.g. depression, substance dependency, psychotic disorders). The most commonly diagnosed personality disorders are antisocial personality disorder and borderline personality disorder. These are the only personality disorders where guidance on treatment and management is given by the National Institute of Clinical and Care Excellence (See NICE guideline 77 and 78).

5. The case for change

5.1 Current Service Usage

Accurate data on the number of people diagnosed with personality disorder accessing our Community Mental Health Recovery Services (CMHRSs) is unavailable as ICD-10 codes have not been routinely employed. However, within the national care cluster framework, people with a personality disorder are most likely to be in cluster 8. The Trust's information management system indicates that there are typically 800 people falling within cluster 8 who access our Working Age Adult (WAA) services at any one time. 81.5% (N = 652) of

these individuals are seen with the CMHRSs and 18.5% (N = 148) are receive acute care services (i.e. Home Treatment Team or inpatient care). The total number of people falling within cluster 8 represents 12% of people accessing WAA services and significantly is below the national prevalence estimates of 30-40%.

In terms of our inpatient services, a survey of 2012/13 discharge rates shows that198 people diagnosed with personality disorder were discharged during this time period which is equivalent to 8.42% of the total annual discharges. The average length of stay for people diagnosed with personality disorder was 21 days.

During 2013/14 the Trust's Delegated/Specialist Commissioning function funded service for 18 individuals diagnosed with personality disorder whose need for security and therapeutic intensity could not be met within the Trust. The majority of these placements (N = 16) were in specialist inpatient facilities and the remainder (N = 2) were provided via community based specialist therapy services. From the available data on admission a discharge dates, including forecast discharges, the average length of stay for people with personality disorder in specially commissioned beds is 18 months, ranging from 1 month to 5 years. It should be noted that an additional 15 people were funded through the Trust's Specialist Commissioning function in 2012/13 but financial responsibility for these individuals transferred to NHS England on 1st January 2014.

5.2 Current Service Delivery

Information about the quality and effectiveness of current service provision for people with personality disorder was gathered from across the Trust. A summary of the key points is presented below:

- A broad range of NICE recommended interventions are available within the Trust but current pathways are unclear and service provision is variable across localities.
- The proposed 2012 strategy for improving services for people diagnosed with personality disorder has not been fully implemented for a variety of reasons and has therefore not delivered the vision of a more equitable and co-ordinate approach.
- There has been reluctance in some teams to diagnose Personality Disorders and diagnostic rates are below the estimated population prevalence.
- Multiple or inappropriate referrals to different parts of the treatment system can occur.
- Decisions about which therapeutic intervention should be offered is often made by staff in care coordination roles who may not have sufficient knowledge about the most appropriate or effective treatment approaches.
- There is a lack of knowledge and understanding of personality disorders in some services, which can lead to an escalation in risky behaviours and result in crisis and the decision to make an inpatient admission.

- Leadership and professional consensus around the best way to deliver services can been erratic
- People using services can experience delays to access appropriate treatment and care.
- People using our services may have to go through multiple assessments to access appropriate treatment and care and then may still find themselves bounced around the system.
- An individual's readiness to engage in specialist therapy is not well considered at assessment and can lead to high attrition rates or people being rejected from recommended treatments.
- Some treatment and care approaches are under resourced and there can be inefficiencies in the way the workforce is used.
- Non psychologist trained in delivering psychological interventions can be withdrawn from treatment programmes with little notice and reallocated to provide care coordination.
- Support services for carers and families are variable across the Trust.
- There is insufficient opportunity for consultation and reflective practice to support staff in managing complex interpersonal dynamics and multiple risk behaviours often associated with personality disorders.
- There is insufficient support for positive risk taking to enable people to be managed in the community rather than through inappropriate inpatient admissions or costly specialist placements.
- There is a current lack of NICE recommended interventions for people diagnosed with Antisocial Personality Disorder.

5.3 The Case for Change

It is clear that despite being able to offer a broad range of NICE recommended interventions for people with personality disorder, equity of access and consistent standards of care across the Trust's services have not been fully realised. This strategy is intended to provide a framework to ensure high quality and timely treatment and care is accessible to people with personality disorders who use our services, their carers, and families.

6. Strategic Aims and Objectives

Our high-level strategic aims and objectives for the next 3 years are set out below and a plan describing key deliverables can be found in appendix 1. Performance will be monitored against the plan on a six monthly basis and wherever possible any barriers to implementation will be identified and addressed through this process. Progress will be reported to the Trust's Executive Board.

6.1. Equal Access

We want our services to be easily accessible to people with personality disorders and delivered close to the point of need. We aim to promote social inclusion by ensuring our care packages are age appropriate and sensitive to a range of factors such as people's gender, ability level, sexual orientation,

and social, cultural and spiritual needs. We will continue to work hard to engage the most vulnerable in our society and improve access for underrepresented groups, such as those from minority ethnic backgrounds, and lesbian, gay and transsexual people.

6.2. Building Kind and Respectful Environments

We will work in partnership with people with personality disorder and their families to ensure good clinical care and shared decision making. People using our services should experience a genuine, consistent and compassionate approach and routine feedback on how we are doing will be gathered to continuously improve service delivery.

6.3. Holistic Approach

Our assessment and care planning approach will be based on a holistic needs assessment that takes into consideration the connection between mind and body, family and friends, community and environment. We will work closely with our partners across the statutory, voluntary and independent sectors and local communities to ensure a whole systems approach that works for the benefits of individuals using our services and their families.

6.4. Prevention and Early Intervention

Young people with emergent personality disorders and their families will be offered a timely assessment and evidence-based treatments through our Children and Young People's Services (CYPS). Any young person who needs to transfer to our adult services (WAA) will have a personalised transition plan and be supported through joint meetings between CYPs and WAA teams.

We will ensure effective links are in place with our IAPT and Infant Mental Health services to promote maternal mental health during pregnancy and after birth and individuals with more significant mental health problems will be offered specialist targeted interventions through our secondary care services. We will pay particular attention to the health and wellbeing of young parents accessing our CYPs and WAA services.

People with personality disorder are at increased-risk of experiencing poor physical and mental health. We will work with our partners to reduce risk factors for health problems and promote healthy lifestyle choices. Our workforce will take a proactive approach by using every contact as an opportunity to check health status and promote wellbeing.

6.5. Think Family

The views and needs of children & families of people with a personality disorder will be carefully considered as part of our assessment and care planning processes. We will provide practical and emotional support to families and carers to help maintain their own health and wellbeing. This may mean working directly with families or navigating them to services offered by partner agencies. We will take a "no wrong door approach" to improve access to our services and ensure our teams are thinking in a joined up way about the needs of families.

6.6. Integrated Care Pathways

Our Personality Disorder services will be based on a model of stepped care tailored to the needs of each individual and focused on recovery. In the first instance, we will work with our partners in the statutory, voluntary and independent sectors to ensure people's basic needs for living are met (e.g. housing, financial, occupational), to reduce risk, and to promote emotional and behavioural stability. For those most in need we will offer a range of targeted, high quality and evidence-based interventions.

6.7. Risk & Crisis Management:

We feel it is important to continue to promote recovery and choice as part of our comprehensive risk assessment and management processes. We acknowledge that most people with personality disorder would prefer to have their needs met out of hospital and we will work with other organisations to deliver accessible and effective crisis advice and liaison services. Developments in telehealth and mobile working will enhance our capacity to monitor, treat and support people in their own homes and communities during a crisis. Our overall goal is to reduce admission to our acute hospitals by providing timely and accessible support and treatment options earlier within the care pathways. Where admission is required we will be clear about the purpose, the agreed length of stay, and any risks that are likely to be increased by the individual being in hospital.

6.8. Protect the Most Vulnerable

At times some of the people we serve may need to rely on others to keep them safe and make decisions for them. We will work with families, carers and partners in other agencies to agree advance plans to keep people safe if they are too ill or lack capacity to direct their own care. We have developed systems and processes to make sure these decisions are taken and reviewed in people's best interests and we will continually seek to maintain the individual's dignity and human rights.

6.9. Consultancy and Training

This strategy is based on strong partnership with other agencies in the statutory, voluntary and private sectors. We will use our expertise to provide consultancy, training and advice to help our partners understand the management of personality disorders and ensure greater integration of care. It is essential to reduce unhelpful splitting between agencies that can give rise to poor, uncoordinated responses, especially for those individuals who pose a high risk of harm and suicide.

6.10. Outcome Focused

Our approach will be outcome focused and feedback from people using our services will be used to continually improve quality and safety. We will aim to improve health and wellbeing outcomes, reduce risk and people's reliance on emergency resources, and promote access to employment, training or vocational activities.

7. The Care Pathways

The care pathways for Borderline Personality Disorder and other Personality Disorder types are shown below in figures 1 and 2 respectively.

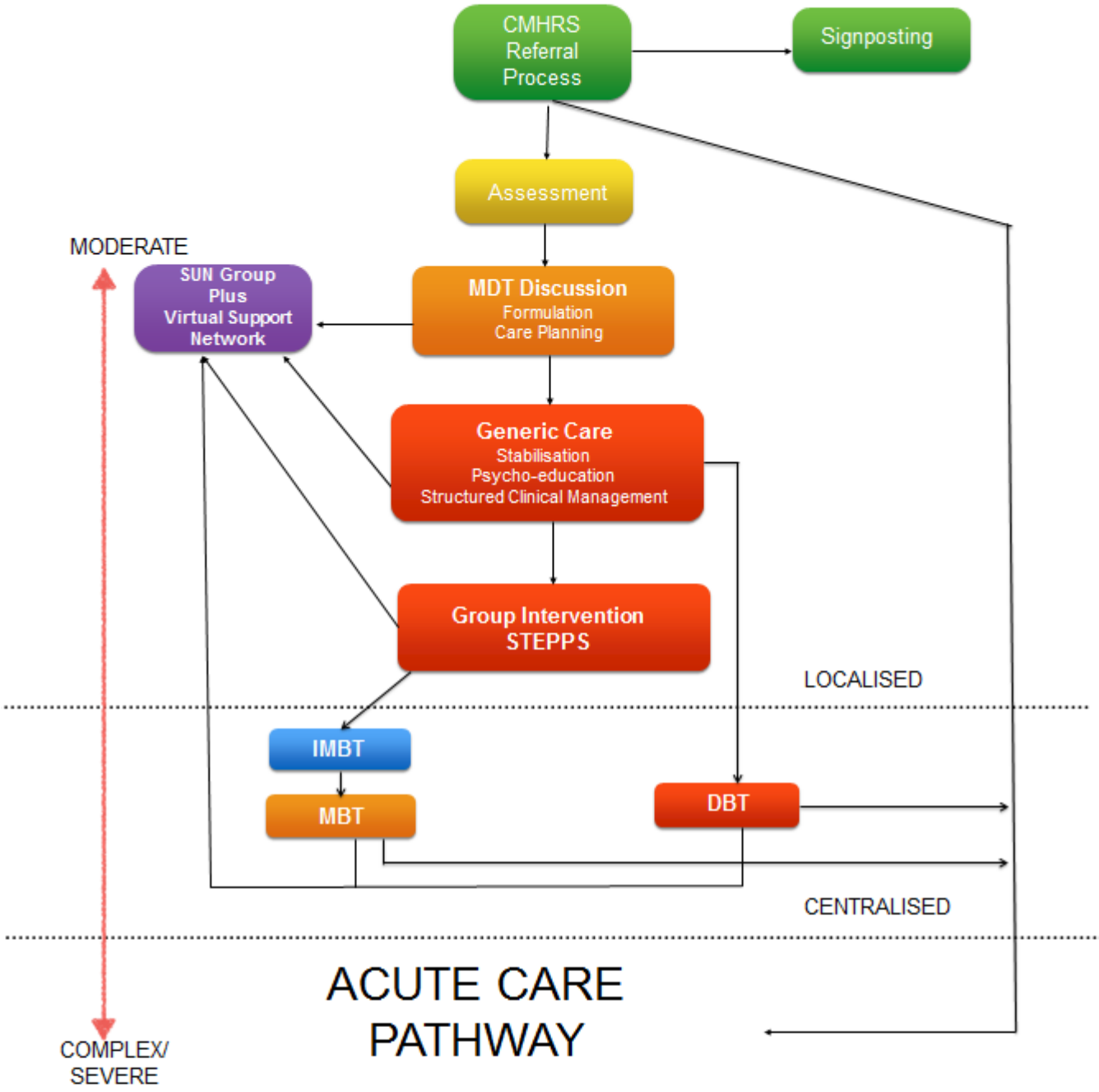
7.1 Referral

Referrals will be accepted from all health and care professionals and from the police and will follow the generic thresholds and screening processes for Working Age Adult Services. Individual's meeting the access criteria will be allocated an assessment slot and those that do not will be signposted to the most appropriate partner organisation to meet their needs.

7.2 Assessment

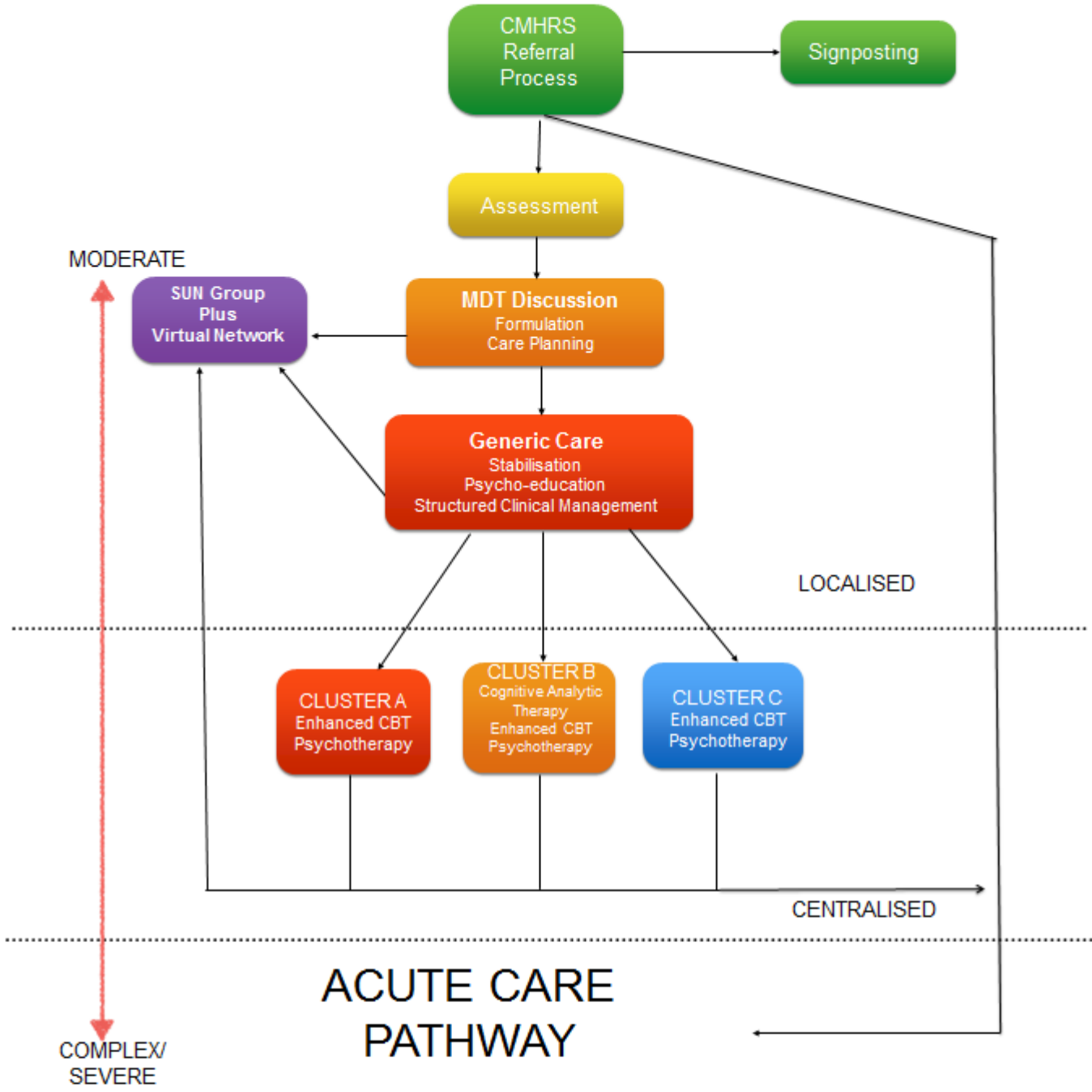
Individuals invited for an assessment will be seen at their nearest CMHRS. The initial assessment will be holistic and robust, following a prescribed format. Co-morbid personality disorders, other mental health problems, underlying medical conditions and social and environmental factors will all be considered, alongside risk assessment and safeguarding issues. In the first instance, the assessment will be conducted by a single healthcare professional and the information gathered will be discussed at the CMHRS weekly multi-disciplinary team (MDT) meeting. Where the MDT perceives the needs of the individual are complex and/or severe, a further assessment may be scheduled involving a second healthcare professional from another discipline. Psychometric measures may also be used to support the assessment. All staff conducting assessments will be competent in working with people with personality disorders (see section 8 for a description of required workforce competencies).

Figure 1: Care Pathway for Borderline Personality



CONSIDER APPROPRIATE DISCHARGE FROM SERVICES AT EACH POINT IN THE PATHWAY

Figure 2: Care Pathway for Other Personality Disorders



CONSIDER APPROPRIATE STEP DOWN FROM SERVICES AT EACH POINT IN THE PATHWAY

7.3 Formulation and Care Planning

The aim of a formulation is to explain the development and maintenance of the person's difficulties. Formulations, diagnoses and care plans will be completed in collaboration with the individual and their family. At this point a Care Coordinator is usually allocated who will work jointly with the person using our services to support and encourage them to take forward the actions on the care plan. The care plan will be delivered in a structured, consistent way and will be periodically reviewed in the light of new assessment or intervention information and as part of the CPA process. We recognise that it is crucial to have well thought through crisis and contingency plans based on a robust risk assessment.

7.4 Intervention

We believe that involving people in the design of their care is an essential ingredient in our success. This means being open, honest and realistic about what kinds of help we can offer and being clear about the consequences of an individual's choices. As part of our recovery focused approach we will provide peer support, education and coping strategies to promote stability and wellbeing and we will also offer a range of targeted, high quality and evidence-based interventions for those most in need. To ensure an integrated approach to care planning and delivery we will collaborate closely with partner agencies.

All our interventions are time limited and they will be tailored to meet the needs and capacity of the individuals using our services. Generic support and less specialised treatment and care should be available within all localities but specialised treatments will be more centralised and cover a broader geographic area. Our stepped care pathways offer the following interventions (see figures 1 and 2).

7.4.1 Generic Support

The Service User Network (S.U.N): This is a peer support group aimed at helping people cope with personality disorders and their associated emotional and/or behavioral difficulties. People attending the group will be helped to feel more supported and empowered by learning new coping strategies and sharing experiences with other people in a similar situation. The S.U.N group is based on a tried and tested model (Miller, Jones and Warren, 2011) and has been shown to help people with personality disorders manage crises and access appropriate services when needed. It follows a Coping Process Theory model and has an agenda that enables sharing of difficulties and a common goal of seeking solutions. Those attending the group will be expected to complete Crisis and Support/Contingency Plans. Structured groups will be held in community venues for 2.5 hours, three days a week, and will have an open door policy for self-referrals. For people stepping down from our services, we will navigate them towards the group and support them with access. The S.U.N group will be developed as a joint enterprise between Surrey and Borders Partnership and a voluntary sector provider. People using services will also be encouraged and supported to participate in the running of the groups.

Stabilisation: Supporting people with personality disorders who are using our services to feel safe and contained is a crucial first step. We will place an early emphasis on working with partner agencies to address housing, finance, drug and alcohol problems, eating disorders, and physical health problems to promote wellbeing and stabilisation. We recognize that people who use our services are knowledgeable about their own health conditions and need to be fully involved in care planning and decision making processes.

Psycho-education: We will provide easy access information in a range of formats to help people understand more about their health needs and encourage them to take greater responsibility for their own wellbeing. Care coordinators will use this information to support and empower people to meet the goals identified in their care plans.

Structured Clinical Management: We will offer well-structured treatment and care within our Community Mental Health Rehabilitation Services as part of an integrated and holistic care plan. Our structured clinical management will offer a predictable treatment timetable and consistent care-coordination. Staff changes will be anticipated and minimised wherever possible. The treatment programme will involve individual and group problem- solving components. Groups will be run on a modular basis and will cover key symptom areas associated with Borderline Personality Disorder, such as emotion regulation, impulse control, interpersonal sensitivity and problems, suicidality and self-harm. Each group will last for 1.5 hours and will be open for people using our services to join at any time (Bateman and Krawitz, 2013).

Virtual Support Network: We will develop a web-based health and wellbeing platform that will enable people who are stepping down from our services to access support and additional psycho-educational materials. The aim will be to encourage people to take greater control over monitoring and managing their health status and to ease the transition out of services. The virtual support network will be administered by facilitators within the S.U.N group.

7.4.2. First Level Intervention for Borderline Personality Disorder

Systems Training for Emotional Predictability and Problem Solving (STEPPS): STEPPS is a structured, skills based group program that runs weekly for 20 weeks and is accessible through local CMHRSs. Individuals attending the group will learn about the behaviors and feelings that define Borderline Personality Disorder and learn a variety of emotion and behavioral management skills. Participants work on changing the way they think about themselves, the world, and other people. They also learn to address problematic lifestyle behaviors such as eating, sleep patterns, exercise, leisure activities, physical health, and relationships. Individual progress will be reviewed at the end of STEPPS and the care plan may indicate a need to revisit parts or the entire programme again to reinforce learning. Alternatively the plan may be for discharge, with signposting to the S.U.N group or other community resources. Some graduates from STEPPS will wish to access our

virtual support network as part of a phased transition plan out of services. For those with complex and enduring needs, the plan will be to move into one of the specialist interventions listed below.

7.4.3. Specialist Interventions for Borderline Personality Disorder

People may access one of the following specialist interventions following the STEPPS programme or they may transfer directly from generic care. The decision will be based on an assessment of need, personal choice, and the MDT team discussion.

Dialectical Behaviour Therapy (DBT): This is a structured approach drawn from Cognitive Behaviour Therapy, dialectical philosophy, and Zen Buddhist mindfulness principles. There is a balance between acceptance and change, with the key aim of helping people with Borderline Personality disorder to have a purposeful and fulfilling life. The treatment has a weekly group component that focuses on developing skills for mindfulness, emotion regulation, interpersonal effectiveness and distress tolerance. Individuals will also be required to meet with their Individual Therapist weekly and to record their progress on daily report card. Telephone coaching is also offered to people using services and the Team have a weekly consultation session to reflect on progress and practice. The therapy follows a strict hierarchy with self- harm and suicidal behaviors taking first priority before moving the focus to therapy-interfering behaviors and quality of life issues. Our DBT programmes run twice weekly over six months.

Introduction to Mentalization-Based Therapy (IMBT): This is a 12 session psycho-educational group introducing patients to the concept of Borderline Personality Disorder and mentalization. It clarifies what Mentalization-Based Therapy (MBT) is and how it can help people using services. The sessions set the framework for future treatment in a non-threatening way. Concepts are taught and discussed and there are supporting hand-outs and home-work tasks. People who attend IMBT may choose to continue to MBT or have a break before they do so.

Mentalization-Based Treatment (MBT): This exploratory treatment has been informed by psycho-dynamic and attachment theories. The individual with Borderline Personality Disorder is helped to understand more about the workings of their mind and those of other people. Weekly individual and group therapy is used to challenge people's automatic assumptions and they are helped to connect feelings with thoughts. It is a twice a week treatment (an individual and a group session) and lasts for approximately 18 months. Consideration is given to some step-down sessions for individuals who may need them.

7.4.4 Other Personality Disorders

The care pathway for people presenting with other types of personality disorder is described in figure 2. The initial parts of the pathway are similar to that for Borderline Personality Disorder and will not be repeated here. The specialist treatment elements are somewhat different:

- **Cluster A** – Enhanced CBT and Psychotherapy
- **Cluster B** – Cognitive Analytic Therapy, Enhanced CBT and Psychotherapy
- **Cluster C** – Enhanced CBT and Psychotherapy

Access to specialist treatment will depend on assessment of need, personal choice, and the MDT discussion.

Enhanced Cognitive Behaviour Therapy (CBT): Cognitive behavioural therapy (CBT) is a family of different therapies which aim to address maladaptive patterns of thinking and behaving. CBT therapies are structured, goal orientated and time limited. CBT emphasises collaborative and open therapeutic relationships and uses a formulation to help the individuals to better understand and manage their difficulties. CBT models of personality disorder, which have most evidence for their effectiveness, tend to emphasize childhood environmental influences on the development of such disorder and focus on deeper level cognitions for the treatment of this disorder. A number of different techniques have been developed specifically to work at this cognitive level. The length of CBT treatment for personality disorder will depend on the CBT model being used but most commonly the treatment will take between 12 to 24 months.

Psychotherapy: We offer a range of psychotherapy interventions - mainly psychodynamic psychotherapy, mentalization-based therapy and transference focused psychotherapy.Within these treatments the individual is helped to consider what has happened in the past and how the past affects current feelings, thoughts and behaviors. The relationship between the therapist and person using services is important in exploring internalized early relationships with care-givers and important others. The part the individual plays in their relationships is explored. This therapy is exploratory and unstructured and can stir up feelings and memories that have been pushed aside. Therapy is offered either on a weekly individual or group basis. Brief psychotherapy lasts for 6 months, whereas individual or group psychotherapy last approximately 18 and 24 months respectively. Our psychotherapy interventions can also include access to art and music therapy.

Cognitive Analytic Therapy (CAT): Is based on an understanding of human relationships drawing on ideas from cognitive, relational and analytic therapies. It offers a highly collaborative way of understanding and working with the self-defeating ways a person thinks, feels and acts.CAT emphasises the events and relationships (often from childhood or early in life) that have helped to shape the person's experiences and to maintain their current problems. It is tailored to the person's own manageable goals for change, helping them develop new ideas for the way they relate to others and, crucially, how they regard and treat themselves. It is time-limited and structured, using written reformulation and end of therapy letters, relationship-based 'mind-maps', and focused self-observation. CAT works intensively with issues around the ending of therapy which is so important for many with a diagnosis of personality disorder.The standard CAT treatment length for

personality disorder is 24 or 32 sessions, with two follow up sessions typically at 3 and 6 months.

7.4.5 Medication

There is no recommended medication for treating a personality disorder. Where medications are prescribed it should be with a clear, documented rationale indicating what symptomatology is being targeted. Regular reviews are important to monitor the benefits of the prescribed medication and their side-effects.

7.4.6. Complex Case Consultation Group

A monthly consultation group comprising specialist therapy leads and a senior medic and nurse will be available to review and provide advice to teams and wards about complex cases. Where there are co-morbid problems such as drug and alcohol use or forensic issues, other expert practitioners will be invited to participate in the consultation process. The aims of the consultations are to:

- Provide an external and reflective perspective to help healthcare professionals avoid getting caught up in complex interpersonal dynamics;
- Review risk and care plans;
- Review treatment outcomes and required length of time in services;
- Advise on alternatives to admission wherever possible;
- Advise on the need for specially commissioned external placements.

7.4.7. Acute Care Pathway

Admissions are not always helpful for people with personality disorder but may be needed for short periods of planned respite or in response to the level of risk posed. Our aim is to use complex case consultation to reduce admissions and enhance community treatments but where there is a need, the rationale and required length of stay should be clearly articulated from the outset. For those requiring a brief hospital admission there should be a range of structured activities available which will offer stimulation, psycho-education and emotional/behavioural regulation skills development. Discharge needs to proactive and planned to prevent relapse and there needs to be organisational support for a positive risk taking approach. The individual's discharge plan will connect them with earlier stages in our care pathways, including signposting to the S.U.N group. Specialist supervision will be available via the complex case consultation group to inpatient staff to help them maintain a valuing and consistent approach to working with individuals with personality disorders.

7.4.7 Delegated/Specialist commissioning

External placements offering a particular intensity/modality of treatment or level of security may be required at times if no local alternatives can be found. However, a thorough assessment of need and full consideration of treatment options available within the Trust nees to be completed beforehand. The requirement for an external placement should be endorsed by the complex case consultation group. Where interventions are delivered by external placement providers, outcomes need to be carefully monitored and a

proactive discharge plan for stepping the individual back down into Trust services needs to be developed at an early stage.

7.4.8 Comorbidity

Where people with personality disorders have additional difficulties, such as substance use, criminal activity or eating disorders, a joint care planning process should be undertaken. However, access to the personality disorder pathways will be through the individual's local CMHRS and additional specialist support and advice will be added by other relevant team/s. An example of this would be the development of CBT based groups provided jointly between the Trust's Forensic Services and CMHRSs. This would address the current lack of NICE recommended interventions for people diagnosed with Anti-social Personality Disorder.

8. Workforce Competences

We will adopt the competency framework for healthcare professionals working with people with personality disorders developed by Roth and Pilling, (2008). This is shown in figure 3 and includes generic and specific competencies.

- **Blue and orange shading**: Competences in these areas should be demonstrated by all staff providing interventions for people with personality disorders.

- **Green and yellow shading:** Competences in these areas should be demonstrated by healthcare professionals who have had the appropriate training and supervision to carry out the specific interventions.

The competency framework will provide the following functions:

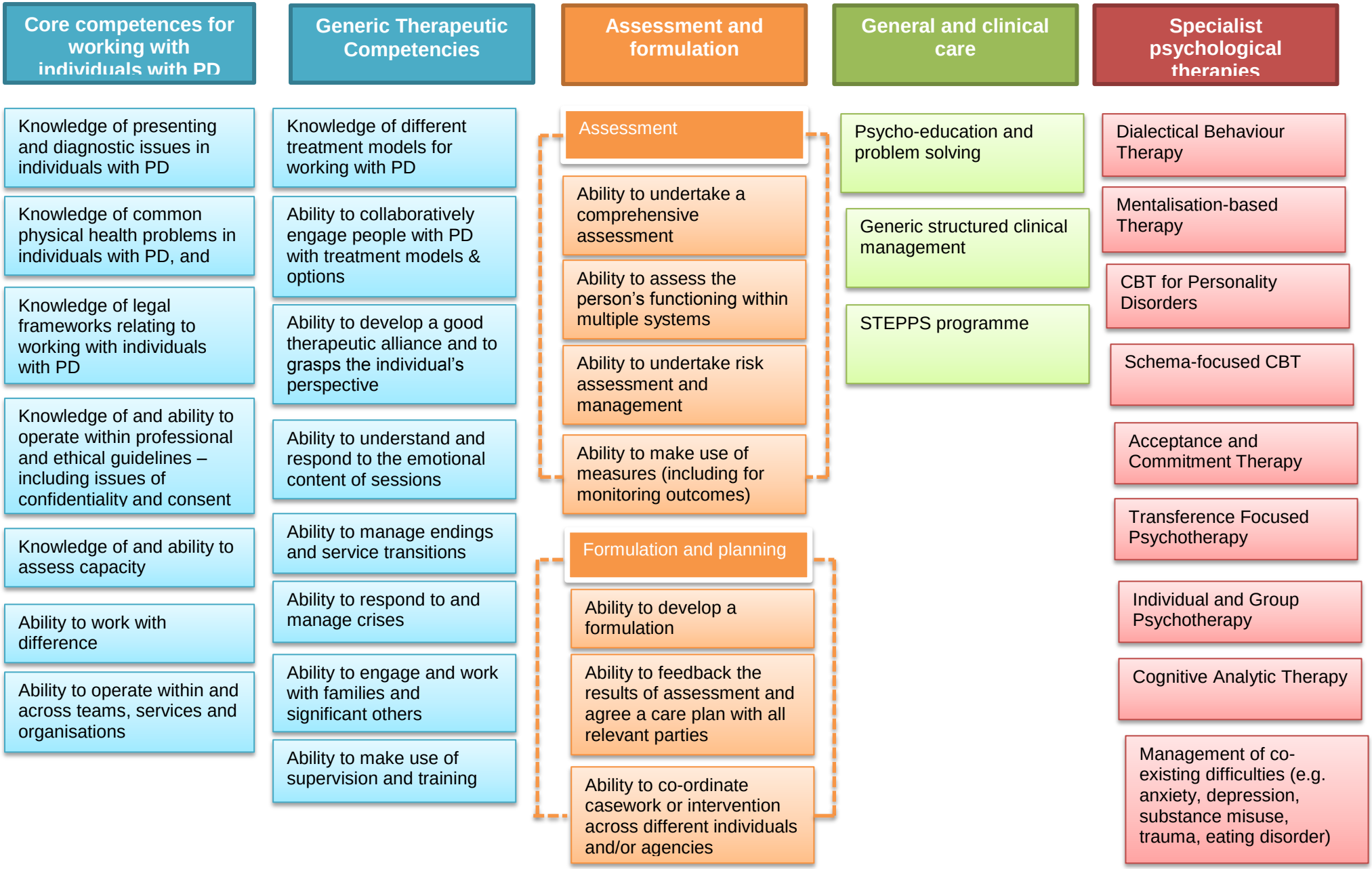
8.1. Clinical Governance: Monitoring the quality and outcomes of our interventions for people with personality disorder is a key part of our clinical governance activity. Embedding this competency framework will allow us to ensure that interventions are provided in a way that is most likely to bring about real benefits.

8.2. Supervision: Supervision and reflective practice are critical when working with people with personality disorders and we are committed to ensuring that our workforce is provided with regular, high quality supervision. The competency framework will be used to improve the quality of supervision by focusing on skills and attitudes that are known to be associated with the delivery of effective treatments and improved practitioner performance.

8.3. Workforce Development and Training: The competency framework will be used in staff appraisals and will provide a reference tool for formulating personal development plans and a workforce training curriculum. Effective training is vital to ensuring increased access to well-delivered, safe

interventions and to support healthcare professionals who are working with people with highly complex needs.

Figure 3: Competency framework for working with people with Personality Disorder (PD) - (based on Roth and Pilling, 2008)



9. Benefits Realisation

The benefits of implementing this strategy are set out in the following table.

Table 1: Benefits Realisation

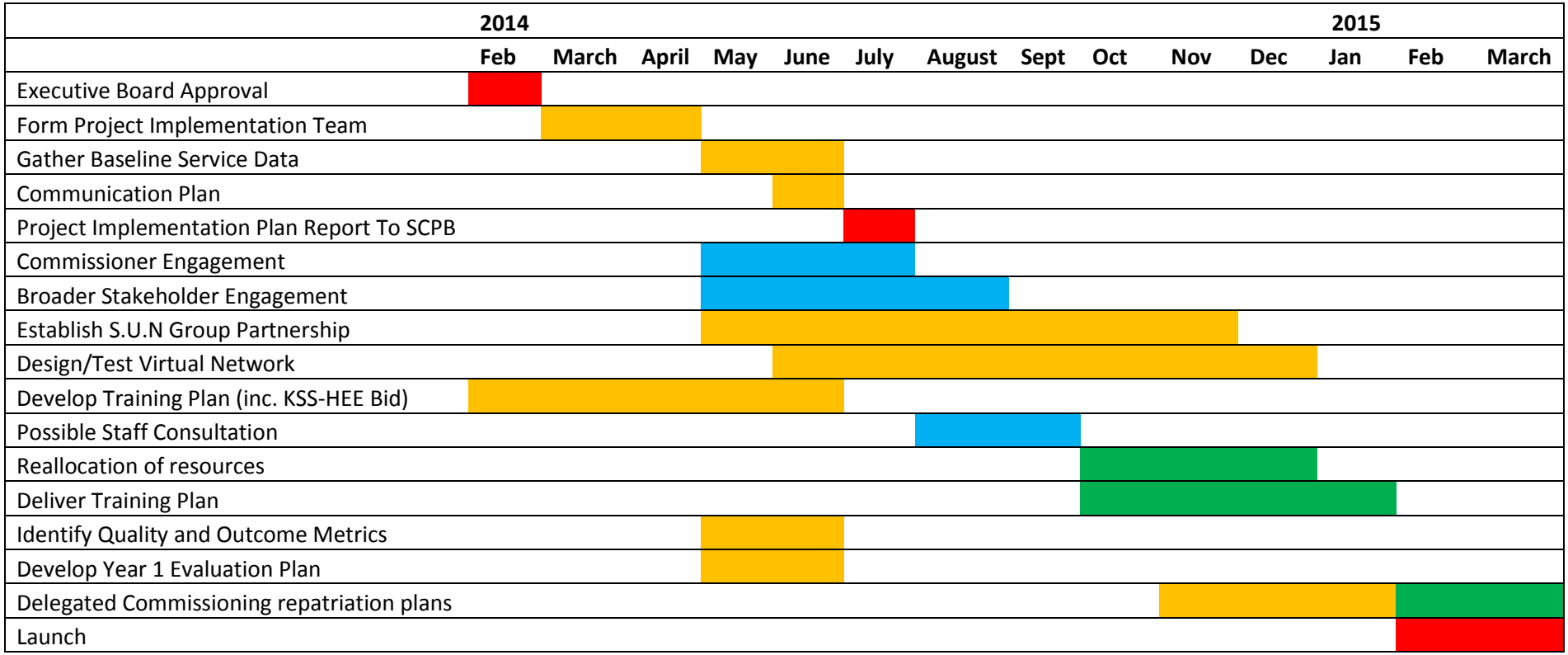
Benefits	Commentary
Strategic	Drives forward the Trust's strategic focus on prevention, diagnosis, early intervention, holistic care, and recovery, thereby improving general health and wellbeing of the communities we serve. The Strategy will enable more specialist and recovery focused work at an earlier stage of people's journey into our services. The will prevent people becoming stuck in services as well as decreasing the number of inpatient referrals and the need to commission specialist external services.
People/Services	The care pathways will improve access to evidence-based treatments and care that aims to improve wellbeing and support recovery for people using our services. This includes both mental and physical health improvements. Think family is a key objective of the strategy to encourage more joined up thinking about the needs of the whole family system and not just the person accessing our services. The Personality Disorders Strategy emphasises protective work in the perinatal period to improve health outcomes for children and families.
Quality, Safety and Efficiency	The aim of the Personality Disorder Strategy is to deliver better clinical care in a more timely way and to manage more people within community services. Increasing workforce skills and extending evidence-based interventions will improve the quality and safety of services. We intend to build a culture of reflective practice by developing a robust programme of staff supervision and support using expert practitioners. This will have a positive impact on working practices and staff wellbeing. The pathways include clear step-down options to support people moving out of our services and to reduce re-referral rates. There are also step-up options to ensure appropriate and evidence-based interventions are delivered in a timely way.
Innovation & Business	The Personality Disorder Strategy incorporates innovative ways of working in partnership with a voluntary sector partner (i.e. Service User Network Group) and the development of a virtual wellbeing platform to enhance recovery and reduce the need for re-referral. The development of a more coherent and evidence-based approach to working with people with personality disorder may provide future opportunities to increase our market share in this area.
Reputational	Ensuring an accessible, consistent and effective approach to working with people with personality disorders and their families will produce reputational benefits for the Trust and promote future successes.
Collaborative	Key to our Personality Disorders Strategy is closer working with partners in the statutory, voluntary and private sectors. We aim to provide a more integrated approach to care planning and to build on the training we already provide to other organisations in Surrey and beyond. One of the essential aims in the strategy is to develop a Service User Network Group with a voluntary sector partner.

Workforce	Adopting the competency framework will make it easier to highlight skill gaps within our workforce and to develop a blended programme of training. We are currently working with Kent, Surrey and Sussex Health Education England and the University of Surrey to pursue funding opportunities to support a workforce development programme.

10. Strategy Implementation Milestones

The strategy implementation plan is described in table 2. It is proposed that a project implementation team should be set up to develop a detailed implementation plan and oversee the delivery of the strategy. The implementation team will report to the Strategic Change Programme Board.

Table 2: Strategy Implementation Plan



KEY	
Milestone	
Plan/Design Phase	
Engagement Phase	
Implementation	

11. Risk Analysis

Some of the key risks associated with implementation of the Personality Disorders strategy are described below along with suggested mitigation.

Table 3: Risk Analysis

Risk	Probability	Impact	Action to Reduce/Manage Risk
There is insufficient data to enable full financial modelling and to support a cost-benefit analysis of the redesign proposal at this time.	High	High	Key deliverables for the first year include a period of intelligence and data gathering to support the development of the project implementation plan. The Plan will include further financial modelling and will require approval by the Strategic Change Programme Board before implementation can go forward.
Insufficient service information to forecast demand and capacity.	High	High	Intelligence needs to be gathered about the number of people diagnosed with personality disorder currently using WAA services and patient flows need to be mapped. A demand and capacity analysis can then be conducted based on this data. This information will need to be included in the project implementation plan.
Insufficient understanding of workforce competence	Medium	Medium	We know there are a broad range of specialist competencies within our existing workforce that support delivery of NICE recommended interventions for people with personality disorder. However, the level and location of competencies requires further mapping. As such, a gap analysis will be conducted across WAA

			services based on the competency framework and findings will inform the workforce redesign and training plan. These details will be included in the project implementation plan.
Failure to secure stakeholder buy-in	Medium	High	A communication plan will be generated and needs to consider the following: 1. There has been significant engagement from the WAA Division in the development of this strategy but wider engagement is recommended. 2. Early engagement of commissioners will be essential to gaining support for the strategy. Some discussion has already taken place as part of the review of specialist commissioning and there may be opportunities to build on this going forward. 3. People who use services, their carers and families need to be involved in the implementation planning for strategy delivery and have a role in overseeing the progress. 4. It is important to identify existing forums where this strategy needs to be disseminated – especially where interdependencies exists (e.g. the acute care pathway redesign).
Failure to implement the strategy.	Low	High	The implementation plan and proposed steering group will ensure delivery of the strategy. The development and delivery of the Personality Disorders Strategy is embedded within the Trust's annual planning process.
Destabilising existing	Low	Medium	Although there are areas of

services that are already working well.			excellent practice within the Trust, problems with access and consistency are prevalent. The strategy has been developed to build on what works well and improve quality. An effective communication plan will be required to build momentum for change and enthusiasm for the strategy.

12. Summary and Recommendations

This strategy sets out to ensure that people with personality disorder who use our services and their families are able to access high quality care in a timely way and within a kind and respectful environment. We believe that people with personality disorders can find new ways to improve their health and wellbeing and fulfil their potential as active and equal citizens. Our focus is on recovery and empowering people to live meaningful lives with or without on-going symptoms of their condition. The proposed care pathways offer time limited, evidence-based interventions that are tailored to meet the needs and capacity of the individuals using our services. The strategy supports greater integration between partner agencies, people using services and their families to ensure we are taking a joined up approach to care planning and meeting people's needs. The Executive Board is asked to approve the direction of travel set out in this strategy to enable Working Age Services to move onto the implementation planning phase.

Dr Helen Rostill
Director of Innovation and Therapies

13. References

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Miller, S., Jones, B., & Warren, F. (2011). The SUN Project: Open access community-based support groups for people with personality disorder. Description of the service model and theoretical foundations. *Therapeutic Communities, 32*,109-124.

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Appendix 1: Key Deliverables

April 2014 – March 2015	April 2015 – March 2016	April 2016 – March 2017
Provide systematic intelligence on current services for people with Personality Disorder accessing WAA services: • Numbers diagnosed • Patient flows • Workforce capacity and competence • Risk management processes • Resource usage – e.g. A&E, Crisis Line, HTT, GPs. • Outcomes • Stakeholder satisfaction	Develop interim steering group (including internal members, people using services and other key stakeholders) to oversee the provision of accessible and equitable services for people with personality disorder across the Trust.	Report of year 1 outcomes to the May 2016 Executive Board and recommendations to support service improvement.
Produce implementation plan to take forward the Trust's Personality Disorders strategy	Increase capacity of CMHRS workforce to conduct robust assessments, formulations and risk management plans.	Interim steering group provide continued oversight to ensure integration of the Personality Disorder Strategy in business as usual.
Produce a communication plan to support the Personality Disorder Strategy and take forward key stakeholder engagement events.	In line with national prevalence rates, increase diagnosis of personality by at least 50% from levels in the previous year (12% to 18%).	In line with national prevalence rates, increase diagnosis of personality by 70% from levels in the previous year (18% to 30%).
Formal consultation process under organisational change policy/procedure and resource reallocation to provide sufficient local coverage and to centralise highly specialist provision.	Improve data capture by ensuring diagnosis, care plan and risk is recorded in the electronic patient record of all patients on the personality disorder pathways.	Diagnosis, care plan and risk is recorded in the electronic patient record of all patients on the personality disorder pathways
Develop and deliver workforce training plan. This includes training in generic competencies and NICE recommended therapeutic interventions.	Demonstrate involvement of families in care planning following the "Think Family" approach.	Families are involved in the care planning process and support packages are delivered consistently across the CMHRSs.

Integrate the Personality Disorder competency framework into ESR to monitor skill development as part of the annual appraisal process.	Develop a consistent approach to psycho-education and structured clinical management groups across the Trust.	Care planning involves other partner agencies to ensure a joined-up and integrated approach tailored to the individual's needs and those of their carers/families.
Develop and implement the Service User Network Group with a voluntary sector partner.	Establish joint planning and intervention processes for delivering coherent and NICE recommended interventions for people with a diagnosis of Anti-social Personality Disorder and those diagnosed with other Personality Disorders who have co-morbid difficulties (e.g. substance misuse or eating disorders).	Outcome evaluation of the Service User Network demonstrates it provides an effective step-down facility that is easy to access and able to manage risk by working in a timely and safe way by working closely with other relevant agencies.
Develop, test and implement the virtual support network.	Demonstrate integrated pathways with statutory, voluntary and private sector partners to improve the care planning process. This includes closer working with GPs.	Regular consultation offered to support CMHRS staff and those working on inpatient wards with people with highly complex needs. The consultation group will continue to provide advice about the appropriateness of commissioning external specialist placements for individual's on the Trust's Personality Disorders pathways. The effectiveness and accessibility of consultations will be evaluated.
Identify quality and outcome metrics and develop year 1 evaluation plan.	Work with voluntary sector partner to deliver the Service User Network group and show clear step-down processes from Trust services to the group.	Reduce the number of admissions of people with a diagnosis of Personality Disorder to the Trust's acute inpatient wards by at least 30% from the previous year. Where admission is required, a clear rationale and discharge plan will be recorded in the electronic patient record.
Launch the Trust's redesigned Personality Disorder Services.	Establish the consultation group and develop the standard operating procedure to ensure ease of access and effective support for staff working in CMHRSs and inpatient wards with	Reduce the average length of stay of people with Personality Disorder admitted to the Trust's inpatient wards by just over 25% from the previous year's levels from 15 to 11 days.

	people with complex needs. The consultation group provides advice about the appropriateness of commissioning external specialist placements for individual's on the Trust's Personality Disorders pathways. The effectiveness and accessibility of consultations will be evaluated.	
Develop the care pathways to begin repatriation of people receiving services outside the Trust via the Delegated Commissioning function. In the first year the aim is to return 20% (4 people).	Repatriate remaining 80% of people receiving services outside the Trust via the Delegated Commissioning function.	Continue to deliver rolling programme of training via the Learning and Development Plan. This will involve a blended approach of e-learning, taught workshops and external training for highly specialist therapy skills. Evaluate the impact of training.
	Reduce the number of inpatient admissions to the Trust's acute wards for people with personality disorder by at least 20% from the previous year. Where admission is required, a clear rationale and discharge plan will be recorded in the electronic patient record.	Reduce the number of people with Personality Disorder who require specially commissioned external inpatient or community provision by at least 10% from the previous year. People with highly complex needs may require services commissioned outside of the Trust due to the need for a secure placement offering intensive therapy. Only those meet the national criteria for tier 4 placements will be eligible for NHS England Specialist Commissioning provision.
	Deliver expert consultation to inpatient ward staff working with people with Personality Disorder to reduce the average length of stay by just over 25% from 21 days to 15.	Negotiate reinvestment of savings in the specialist commissioning budget into the Trust's CMHRS provision and Service User Network Group.
	Reduce the number of people with Personality Disorder who require specially commissioned external inpatient or community provision by at least 10%. People with highly complex	Supervision, annual appraisals and professional development plans of staff working with people with personality disorders will include the competency framework and be

	needs may require services commissioned outside of the Trust due to the need for a secure placement offering intensive therapy. Only those meet the national criteria for tier 4 placements will be eligible for NHS England Specialist Commissioning provision.	recorded on ESR.
	Negotiate reinvestment of savings in the specialist commissioning budget into the Trust's CMHRS provision and Service User Network Group.	Complete year 2 evaluation of health and wellbeing outcomes, service experience, risk reduction, emergency resource use and access to employment, training and/or vocational activities.
	Deliver rolling programme of training via the Learning and Development Plan. This will involve a blended approach of e-learning, taught workshops and external training for highly specialist therapy skills. Evaluate the impact of training.	
	Supervision, annual appraisals and professional development plans of staff working with people with personality disorders will include the competency framework and be recorded on ESR.	
	Complete year 1 evaluation of health and wellbeing outcomes, service experience, risk reduction, emergency resource use and access to employment, training and/or vocational activities.	

Appendix 2: Equality Impact Analysis

1. About the policy/project/change

Title of the project	Personality Disorders Strategy for Working Age Adult Services
What are the intended outcomes / changes expected as a result of this policy / project / change:	The aims are to ensure that people with personality disorder who use our services and their families are able to access high quality care in a timely way and within a kind and respectful environment. The focus is on recovery and empowering people to live meaningful lives with or without on-going symptoms of their condition. The proposed care pathways offer time limited, evidence-based interventions that are tailored to meet the needs and capacity of the individuals using our services. The strategy supports greater integration between partner agencies, people using services and their families to ensure we are taking a joined up approach to care planning and meeting people's needs.
Are there links with other existing policies/projects: (if yes – provide details)	SABP Organisational Change Policy Supervision Policy Cost Improvement programmes

2. Decide if the policy / project / change is equality relevant

Yes, it affects the workforce and people who use services

3. Gathering evidence to inform the equality analysis

The Protected Characteristics & Evidence: Using the relevant available evidence - what is known, understood or assumed about each of the equality groups / protected characteristics identified below that could be relevant to this policy / project / change. Record the sources of the evidence used	
Age	There are no specific concerns relating to equality groups or those with protected characteristics. The strategy aims to improve access for all people using the Trust and emphasizes the need to engage people who are often under-represented in services. If workforce redesign is required as the strategy is implemented, it will be managed under the Trust's Organisational Change Policy to ensure a fair and equitable process.
Caring responsibilities	
Disability	
Gender reassignment (Transgender)	
Marriage and civil partnership (applies to employment only)	
Pregnancy and maternity	
Race / ethnicity	
Religion or belief	
Sex / gender	

Sexual orientation	

4. Engagement and Involvement

Record the names of the people and/or groups involved in gathering evidence and/or testing the evidence against the policy / project / change. Who and how were they involved?	
Who – name of individual / group(s) represented	How involved?
• Helen Rostill (Director of Innovation and Therapies) • Rachel Hennessy (Medical Director) • Andy Erskine (Divisional Director WAA) • Alison Armstrong (Divisional Director OPMH/Specialist Services) • Angela Devon (Associate Director Therapies WAA) • Metka Shawe-Taylor (CBT Lead) • Neelima Reddi (Lead Medical Psychotherapist) • Christine Openshaw (Consultant Clinical Psychologist) • Sarah Swan (Consultant Clinical Psychologist) • Tessa Lippold (Consultant Clinical Psychologist) • Helen Wood (Service Manager) • Alasdhair Caldwell (Consultant Psychiatrist) • Sajad Yusef (Consultant Psychiatrist) • Ward Lawrence (Consultant Psychiatrist) • Phil Ferreira-Lay (Consultant Psychiatrist) • Sophia Ali (Consultant Psychiatrist) • Julie Smith (Consultant Nurse) • Rebecca Isherwood-Smith (Occupational Therapist) • Jo Jennison (Clinical Psychologist) • Josephine Rowland (Clinical Psychologist) • Julia Chambers (Expert by Experience)	Individual Discussions Meetings with Divisional Directors Task and Finish Group

5. Analysis of the potential impact of the policy / project / change
Based on the evidence you have gathered; describe any actual or likely impacts that may arise as a result of the decision and whether these are likely to be positive or negative.

Eliminate discrimination, harassment and victimisation:	
Caring responsibilities	For people caring for an individual with a diagnosis of personality disorder, the strategy should have a positive impact by increasing support and involvement. The principles of our "Think Family" approach are embedded within the strategy. For staff delivering the strategy, working patterns and localities may change. Before making any decisions about the workforce, further analysis of capacity and competence is required. However, redesign is likely and any affected staff will be supported to ensure that changes do not adversely affect their role or responsibilities as carers.

Disability	The strategy aims to make access to generic services and support easier for all by increasing capacity and reducing locality variations. This should have a positive impact on individuals with a disability. However, more specialist treatment services may become centralised and the impact on people with disabilities (staff, people using services and their carers/families) will need to be specifically assess and reasonable adjustments will be made where appropriate to support transition.
Age Gender reassignment Marriage & civil partnerships Pregnancy & maternity Race / ethnicity Religion or belief Sex / gender Sexual Orientation	The strategy make particular note of improving access for people who are often under-represented in our services. The focus is firmly on inclusion and the project implementation team will consider this further in the project and communications plan. A good example, is the focus on improving perinatal mental health by supporting families during pregnancy and beyond. For our workforce an equitable and transparent implementation process will be managed under the Trust's Organisational Change Policy to ensure people are treated equally.

Advance equality of opportunity:	
Age Caring responsibilities Disability Gender reassignment Pregnancy & maternity Race / ethnicity Religion or belief Sex / gender Sexual Orientation	Opportunities for people using our services with a diagnosis of personality disorder, their carers and families will be enhanced by our focus on recover. We intend to work closely with other partner agencies to enhance opportunities for people to improve their health, wellbeing and social outcomes. This includes supporting people to find more stable accommodation, employment, training and vocational experiences. For our workforce there will be more opportunities for all to engage in competency based training which may lead to career advancement.

Promote good relations between different groups:	
Sex / gender	
Age Caring responsibilities Disability Gender reassignment Pregnancy & maternity Race / ethnicity Religion or belief	There will be no impact: the strategy focuses on improving access and outcomes for all people using services. The aim of the proposed Service User Network is to bring people together who have a diagnosis of personality disorder and promote the benefits of peer support. For the workforce, having clear and evidence-based care pathways should improve co-operation and ensure a full range of approaches, interventions and skill sets are equally valued.

Sexual Orientation	

What do you consider the overall impact: The strategy will have a positive impact as services become more accessible and consistent across the Trust. People using services, carers and families will also be encouraged to become more involved in services and in taking control over their own health needs. Implementing the strategy may result is some workforce changes but in general access to competency based training and expert support should be beneficial.

6. Action Planning

Actions to be taken as a result of this analysis (add additional rows as required):	Person to action	Completion date
1. The project team to ensure a robust workforce and communications strategy is in place to support engagement.	Project Implementation Team	May – Sept 2014

7. Authorisation

Name & job title of person completing this analysis:	Helen Rostill (Director of Innovation and Therapies)
Date of completion:	February 2014
Name & job title of person responsible for monitoring and reporting on the implementation of the actions arising from this analysis:	Project Implementation Team Lead (TBC)
Name & job title of authorised person: (If there are doubts about the completeness or sufficiency of this equality analysis, seek advice from the Equality and Human Rights Team or the Legal Services & Reporting Manager in the Clinical Risk & Safety Team)	Andy Erskine (Director Working Age Adult Services)
Date of authorisation:	