North Essex Clinical Commissioning Groups

Personality Disorder Strategy

(2015 – 2017)

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CONTENTS

Section 1: INTRODUCTION

Our vision for personality disorder services in north Essex

This Health Care Strategy has been written in union with North Essex Clinical Commissioning Groups (CCGs) and clinicians from North Essex Partnership University NHS Foundation Trust (NEP) and sets out the vision and provides a detailed explanation of the standards and course to commissioning and delivering personality disorder (PD) services in north Essex moving towards 2017. Although PD is seen as a common condition, there is considerable variation in severity, and in the degree of distress and dysfunction caused.

We aim to ensure that all our commissioned services will have an understanding of personality disorder and that providers of mental health services will have PD embedded in their ethos through integrated teams where service users' needs will be matched with clinical skills.

Section 2: BACKGROUND

National policy & local context

The strategy published by the Department of Health (DH) in February 2011, No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, uses the phrase 'mental health problem' as an umbrella term to denote the full range of mental ill health and disorders, including personality disorder and refers to personality disorder as *"Any disorder in which an individual's personal characteristics cause regular and long-term problems in the way they cope with life and interact with other people and in their ability to respond emotionally."*

The National Institute for Mental Health in England's (NIMHE) previously published paper in 2003[1] is specific to PD services and the first document which sets policy guidance for the development and provision by Trusts, of services for people with personality disorder. Objectives within the guidance can be condensed to:

- To assist people with personality disorder, who experience significant distress or difficulty, to access appropriate clinical care and management from specialist mental health services.
- To establish necessary education and training to equip mental health practitioners to provide effective assessment and management.

Ten months later, this paper was followed by "The Personality Disorder Capabilities Framework – Breaking the Cycle of Rejection"[2] which outlines the skills and abilities required by practitioners to deliver good quality services within personality disorder services, mainstream mental health services, primary care and also in the wide range of other agencies that may be involved in treating and supporting people with personality disorders. The central aim was to create a workforce that has a better understanding of personality disorder to reduce the feeling of rejection. Rejection is often felt by people with personality disorders as they are moved between various systems and agencies.

[1] National Institute for Mental Health in England (2003). Personality Disorder: *No longer a diagnosis of exclusion.*

[2] National Institute for Mental Health in England (2003). Breaking the Cycle of Rejection; *The Personality Disorder Capabilities Framework.*

In January 2009 the National Institute for Health and Care Excellence[3] (NICE) issued guidelines for treatment and management of personality disorder as part of their pathways programme that recommends how health and social care professionals can ensure that users of mental health services have the best possible experience of care from the NHS with strong emphasis on;

- Access to services - Not using BRIEF psychological interventions
- Using more than one type of intervention
- Autonomy and choice - Working in partnership with service users with clear boundaries
- Developing an optimistic and trusting relationship
- The use of care plans with goals and crisis plans
- Professionals working together across the pathway

Section 3: SCOPE

This strategy covers the north Essex commissioning intentions for North East, Mid and West Essex CCGs until March 2017 for the population of north Essex and those registered with a north Essex GP aged 18 years and over. People with PD can make heavy demands on local services; they tend to have relatively frequent contact across a spectrum of these services including mental health and substance misuse.

Personality disorder is associated with complex need and many commissioners and agencies are involved in providing services. PD services are at present commissioned according to a six-tiered model which provides for coordinated services responding to different levels and severity of need, with some services available locally and more specialist responses at a regional level.

Tiers 1-3 are services provided for people with moderate to severe PD, whose mental health needs can generally be met by local community services. These services are commissioned by local CCGs and may include services that include consultation, psychological support, community-based treatment, day services, and crisis support. It is our ambition to align PD services with the North Essex Stepped Model of Care which was developed as part of our North Essex Mental Health Joint Commissioning Strategy for Adults (2014). See Appendix ONE (page 17)

There has been effective engagement with service users, carers and families in developing this strategy (See Appendix TWO – page 19) and we recognise the need for change. By investing in a better model of mental health care there are opportunities to improve quality of services without additional cost.

Section 4: THE CHALLENGES

Personality Disorder Prevalence

Most service users diagnosed with personality disorders fall into the borderline personality disorder (BPD) group. Prevalence of BPD in the general population ranges from 1.4% to 5.9%, and in psychiatric populations is around 20%. In a recent point prevalence survey of north Essex acute inpatients, 26% were found to have a primary diagnosis of personality disorder, largely borderline

[3] http://publications.nice.org.uk/borderline-personality-disorder-cg78/key-priorities-for-implementation

PD; and in a smaller Community Mental Health Team (CMHT) sample the proportion was found to be the roughly the same.

The remaining groups are not so heavily represented in mental health populations:

	Prevalence % per general population
Antisocial	0.2 - 3.3
Narcissistic PD	0 - 6.2
Histrionic PD	1.8
Avoidant	2.4
Dependent PD	0.5 – 0.6
Obsessive Compulsive PD	2.1 – 7.9

The following groups may be more likely to be treated in psychotic clusters.

	Prevalence % per general population
Paranoid PD	2.3 – 4.4
Schizoid	Uncommon in MH settings and little data
Schizotypal	0.6 - 4.6

All of these figures could be challenged with a number of individuals remaining either undiagnosed or misdiagnosed. Personality disorders are more common in younger age groups (25-44yrs) and are equally distributed between males and females[4] with an estimated occurrence rate for any personality disorder being 54 per 1,000 men and 34 per 1,000 women. This would equate to approximately 8,077 males and 5,122 females aged 20 to 49 alone with any personality disorder in north Essex. The male population for this age group in north Essex being 149,568 and the female population being 150,635 mid-year for 2013.[5]

Inpatient Admissions

Research literature and the national policy framework recognise that acute hospitalisation is rarely the most appropriate means of giving care to people with PD. Despite this, hospital is frequently used as an option. Estimates nationally suggest that between 40% and 60% of acute psychiatric beds are occupied by individuals who meet PD diagnostic criteria. Such admissions may be unhelpful if they do not have a clear therapeutic goal beyond promoting short-term safety.

Many patients with Personality Disorder can present with long-lasting suicidality. Inpatient admission is an appropriate response to critical suicidality, but admission as a response to long-lasting suicidality can lead to:

- Delays in dealing with underlying problems
- Draining resources away from psychological approaches
- Reinforcing unsafe behaviour
- More admissions

[4] http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml
[5] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-322718

In addition, there is little evidence that acute inpatient admissions do offer protection from either self-harm or aggression. Risk-driven admission may reinforce unsafe behaviours, wear away a person's own coping skills and weaken their ability to take responsibility for their own actions. Admissions decrease independence and increase stigma.

Education & Understanding

Poor mental health is more common than most people realise and can happen to anybody, it is not discussed as freely as other health conditions which increases the stigma attached to mental health and as a result individuals can often feel shame. Stigma itself is usually a result of the negative view society may have of PD which is routed by fear and misinformation.

"I want to not be treated like a Muppet!"
Service User

Many people with a diagnosis of a PD also have other co-occurring mental health disorders which can lead to misdiagnosis. There is also a high level of comorbidity between different types of personality disorder. The symptoms of PD can be very distressing, bewildering and disabling, not only to the individual and their friends and families but also to staff who try to help. Individuals who have personality disorder suffer from a range of symptoms and difficulties that affect their whole lives, and make it difficult for them to cope and lead a contented life. The honeycomb presented below (Figure One) shows the complexities of individuals who may present with a personality disorder to a range of services, including substance misuse services.

Figure One: Common presentation & contributing factors.

Due to the number of complexities identified above health professionals have not always agreed how best to identify personality disorders, this can lead to a delay in diagnosis or even a misdiagnosis. It can also pose difficulties when interpreting data.[6]

In addition to the difficulties individuals face in being diagnosed, many people believe that if they were informed of their diagnosis in a more meaningful way and were given a clearer explanation they would have a better understanding of their condition and their treatment. The timing of this information is crucial. Many feel they are being informed too late into their diagnosis and in the wrong way.[7]

[6] NHS National Institute for Mental Health England. Personality Disorder; No longer a diagnosis of exclusion. Jan 2003
[7] Forensic Focus 23.Personality Disorder:Temperament or Trauma? Heather Castillo(2003)

The following quotes from individuals within the service were given when asked: "**How did you find out about your personality disorder diagnosis?"**

- *"I asked at a review ….. the psychiatrist told me very reluctantly"*
- *"I asked for access to my notes and found out about Personality Disorder"*
- *"The psychiatrist told me after I asked"*
- *"I read my notes on the computer screen when my GP left the room"*

Significantly these individuals with PD do not respond to standard mental health interventions, and for their part, mental health services are not geared up to help and support them. This is the case even though this group is accounted for in national policies. However, providing appropriate treatment for people with PD requires clinicians to develop particular skills (NIMHE, 2003) as people with PD are likely to:

- Be heavily represented in admissions to general hospital following suicide attempts, particularly those who have repeat admissions. [8]
- Be associated with poor general health outcomes including chronic fatigue, fibromyalgia, joint problems, obesity, osteo-arthritis, diabetes, hypertension, smoking, high alcohol use, increased use of sleep medications and analgesics. [9]
- Have high numbers of contacts with police services. [10]

Medication

Evidence about the efficacy of medication for PD is uncertain and controversial. However, across mental health services a wide range of medication is prescribed symptomatically, including antipsychotic medication routinely.

High levels of emotional distress among some people with PD together with the pressure that clinicians can experience to find quick solutions when individuals present in crisis mean that drug treatments are often used. Local reviews of drug treatments for people with PD suggest that over

8 Preti A, Tondo L, Sisti D, Rocchi MB, de Girolamo G; PROGRES-Acute groupEur Arch Psychiatry Clin Neurosci. 2010 Apr;260(3):181-90. Epub 2009 Aug 6. Correlates and antecedents of hospital admission for attempted suicide: a nationwide survey in Italy.

9 Frankenburg FR, Zanarini MC.J Clin Psychiatry. 2004 Dec;65(12):1660-5. The association between borderline personality disorder and chronic medical illnesses, poor health-related lifestyle choices, and costly forms of health care utilization.

10 Gandhi N, Tyrer P, Evans K, McGee A, Lamont A, Harrison-Read P. Pers Disord. 2001 Feb;15(1):94-102.A randomized controlled trial of community-oriented and hospital-oriented care for discharged psychiatric patients: influence of personality disorder on police contacts.

80% are being prescribed psychotropic medication, often over long periods of time.[11] This review also found that almost two thirds of patients with a personality disorder but no co-morbid psychiatric diagnosis were prescribed an antidepressant; over half have an antipsychotic, two-fifths a sedative and a fifth a mood stabaliser.

This high use of psychotropic medication is not consistent with the recommendations made by NICE.

Commissioning across the whole pathway

At present NHS England has responsibility for commissioning specialised services for people with complex and severe personality disorders (described as tier 4 PD services). The division of the care pathway for people with PD between local CCG and NHS England commissioners poses its own particular challenge.

In some cases this may contribute to difficulty navigating care between organisations and across commissioning boundaries. There may be circumstances where it has the potential to impact on the timely transition of service users between highly specialist services (which might be located out of area and away from service users' families and homes) and non-specialist local services.

This may also be apparent where young people diagnosed with an emerging personality disorder are in transition between NHS England commissioned Children and Adolescence Mental Health Services (CAMHS) hospital services and CCG-funded local adult mental health services.

Section 5: DEVELOPING SERVICES

There is a strong evidence base for therapeutic interventions and psychosocial treatment models.

Dialectical Behaviour Therapy (DBT) - designed to help people change patterns of behaviour that are not effective, such as self-harm, suicidal thinking and substance abuse.
Cognitive Behaviour Therapy (CBT) - a talking therapy that can help you manage individuals' problems by changing the way they think and behave.
Psychodynamic Psychotherapy - a form of depth psychology, the primary focus of which is to reveal the unconscious content of an individuals' mind in an effort to alleviate psychic tension.

These models have been shown to be viable cost effective means of reducing general personality pathology, suicidality, self-injury, A&E visits, psychiatric admissions and bed days.[12] In addition, day hospital treatment and partial hospitalisation are also valid and cost effective treatments for PD.[13]

Inpatient admissions do not necessarily conclusively guard individuals against suicide, as suicides still occur at a high rate in inpatient psychiatric settings. Suicidal behaviour is conveyed generationally,

[11] Prescribing for people with a personality disorder. Prescribing Observatory for Mental Health-UK POMH-UK; CCQI. Royal College of Psychiatrists 2012
[12] Binks CA, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C. Cochrane Database Syst Rev. 2006 Jan 25;(1):CD005652.Psychological therapies for people with borderline personality disorder.
[13] Gratz KL, Lacroce DM, Gunderson JG. J Psychiatr Pract. 2006 May;12(3):153-9. Measuring changes in symptoms relevant to borderline personality disorder following short-term treatment across partial hospital and intensive outpatient levels of care.

constituting a problem which continues in the long term for services.[14] Chronic suicidality can be best managed in an outpatient setting with alternatives which include brief admissions for planned respite/crisis care for up to 48 hours.[15]

Feedback from service users, carers and families helped identify some key areas that would help to tackle the barriers that are faced by those living with PD:

- A person centered service rather than service for a 'label'.
- Continuity of support throughout the system.
- Greater understanding of PD.
- Presentations to GPs/PPG / WI (general practices / patient participation group/woman's institute.
- Excellent relationship (service users/services/community).
- BEING HEARD.

Inpatient Admissions

There has been a highly significant reduction in NHS mental health beds in the last decade, during this time the Mental Health Act Commission has regularly been reporting occupancy rates of over 100% on some 40% or so of adult acute wards visited by the Commission.[16] Inpatient beds are therefore less therapeutic and are themselves a source of stress. Such wards have the capacity to be damaging to staff as well as service users.

Increasing the number of acute psychiatric beds would not necessarily result in an enhanced service, reviews of acute hospitilisation show that hospital admissions are not only not cost effective (see Table One below for current costs across north Essex) but between 30% and 40% of individuals could be accommodated more appropriately elsewhere.[17]

Table One: Estimated costs for inpatient admissions in north Essex

	Mid Essex	North East Essex	West Essex	Total
	£'000	£'000	£'000	£'000
10%	1,074	1,051	730	2,855
20%	2,148	2,103	1,459	5,710
30%	3,222	3,154	2,188	8,564
				17,129*

**Based on current bed costs*

Until recently people with mental health problems in crisis had few options other than admission to an acute ward. However, the falling bed numbers have restricted even this option. The provision of crisis houses which are generally led by the voluntary sector have been introduced throughout the country to fulfil a number of roles which provide better support for people in crisis out of hours

[14] Gureje O, Oladeji B, Hwang I, Chiu WT, Kessler RC, Sampson NA, Alonso J, Andrade LH, Beautrais A, Borges G, Bromet E, Bruffaerts R, de Girolamo G, de Graaf R, Gal G, He Y, Hu C, Iwata N, Karam EG, Kovess-Masféty V, Matschinger H, Moldovan MV, Posada-Villa J, Sagar R, Scocco P, Seedat S, Tomov T, Nock MK.Mol Psychiatry. 2011 Dec;16(12):1221-33. doi: 10.1038/mp.2010.111. Epub 2010 Nov

[15] Paris J. Treatment of Borderline Personality Disorder: A guide to evidence-based practice (2004)

[16] http://www.priory.com/psychiatry/Decline_NHS_Inpatient_Psychiatry.htm

[17] Flannigan C. B., Glover G. R., Feeney S. T. et al (1994) Inner London collaborative audit of admissions in two health districts. 1: Introduction, methods and preliminary findings. British Journal of Psychiatry, 165, 734 -742.

other than A&E, including the provision of short term accommodation.[18] **The accommodation should only serve small groups of individuals for a short defined period of time and it should provide an alternative to hospitalisation**.

Recent evaluations[19] of community-based mental health crisis houses showed significant improvements in symptoms, social functioning, mood and activities of daily living, and a reduction in risk issues. Results also suggest that when services are able to provide interventions preferred by service users, those service users are more likely to be satisfied with treatment.

The North Essex preferred model of care for personality disorder services is a dedicated multi-disciplinary team (MDT) where a group of specially trained practitioners work together, and whilst they may divide their roles, are all part of a specialist service. If good working relationships and close collaboration within the team are fostered treatment is more likely to be consistent and implemented according to agreed protocols. This model also has a particular advantage for people with severe personality disorder who require frequent risk assessment, have multiple needs and demand continual engagement if they are to remain in treatment.

North Essex CCG's will explore the provision of Crisis Houses as an effective alternative to existing urgent care pathways alongside the development of enhanced community teams to keep people out of hospital and in their own homes combined with the use of assistive technologies.

Commissioners from the three North Essex Clinical Commissioning Groups are currently undertaking three pilot schemes which are likely to result in commissioned services from 2015/16 should the pilots deliver successful outcomes. The schemes are community personality disorder enhanced provision, enhanced accident and emergency (A&E) liaison and street triage. Each of these schemes has potential to improve services and outcomes for service users in north Essex with a personality disorder.

Street triage is delivered in collaboration with Essex Police. This scheme aims to reduce the number of section 136[20] detentions in north Essex. A significant number of 136 detentions do not end up in formal section or admission and therefore can be avoided. The aim of the scheme is for service users to be triaged 'on the street' and through the provision of a special helpline to stop them requiring detention and to allow them to be managed instead within the community or through more appropriate service provision.

The enhanced accident and emergency liaison pilot seeks to increase mental health expertise within A&E departments. The service aims to ensure that there are no four hour A& E breaches attributed to mental health within north Essex acute hospitals. The service aims to ensure that mental health users presenting at accident and emergency (often with personality disorder) are treated in a timely manner with appropriate expertise.

The community personality disorder scheme aims to reduce mental health inpatient bed reliance and acute hospital admissions for service users with a personality disorder. The scheme aims to manage service users more effectively within the community in line with the evidence base for PD treatment.

There is an increasing importance of engagement between service at a primary care level to support an improved response for people with PDs and reduce fear of litigation.

[18] Stroul B. A. (1988) Residential crisis services: a review. Hospital and Community Psychiatry, 39, 1095 -1099.
[19] http://bjp.rcpsych.org/content/197/Supplement_53/s32.full
[20] Section 136 refers to a person being detained by police officers under the mental health act and taken to a place of safety.

Input from these PD outreach teams will give the following benefits:

For patients

- Continued integration in existing general mental health services.
- Specialist service provision within existing services.
- Better understanding from staff.
- More cohesive and consistent care plan.
- More structure and containment.
- Inclusion in services where appropriate.
- Less inappropriate treatment, e.g. admissions.
- Greater self-management and independence

For families / carers:

- More information available.
- More support / involvement in care.

Education & Understanding

Underpinning success in the development of any personality disorder service is ongoing training and supervision. The Personality Disorder Capabilities Framework sets out key skills and competencies for staff and is linked to the National PD Knowledge and Understanding Frameworks (KUFs).[21]

The basic level of this framework alone is made up of six online modules assessable through a virtual learning environment alongside three practical training days. The modules have been designed with supporting values to guide the activities and learning.

These values are:

- Starting with the views of people who are doing this work and using these services.
- Connecting service users past experiences with their current behaviours.
- Making sense of reactions and responses within different contexts.
- Developing effective communication skills.
- Developing sensitivity to service user experience.
- Understanding organisations and the importance of teamwork.
- Developing self-awareness and critical reflection skills.

[21] https://www.personalitydisorderkuf.org.uk/

North Essex wants their provider services to ensure the appropriate level of training is accessible to health staff covering the following areas:

- Basic level training in awareness / principles of PD management / principles of assessment and treatment.
- Advice, support and encouragement.
- Consultation / supervision groups to encourage a reflective approach.

Staff attitudes and skills are of high importance within current mainstream services in ensuring appropriate provision for people with PDs. Risks to organisational reputation and potential litigation can mean that service providers adopt a risk adverse approach to individuals' care which does not always meet the service users' needs.

Moving away from this systematic approach in care there must be specific training in:

- Risk (for service user / for organisation).
- Assessment of needs.
- Behavioural management.
- Treatment - based on the understanding of the individual

North Essex CCGs will also work closely with Essex County Council colleagues, including Substance Misuse teams to ensure that appropriate training is accessible to both Social Care and voluntary sector organisations.[22]

GP education:

Lack of consistency in primary care services when it comes to mental health clinical expertise and knowledge of services can be a key factor in the identification, treatment and recovery of people with personality disorder. There is a great deal of evidence to demonstrate that the provision of enhanced education and training to primary care practitioners to increase the confidence and competence of primary care practitioners in managing mental health needs can yield immense benefits in the improvement of population health and patient outcomes.

Enhanced training can provide primary care teams with:

- Timely detection and referral to specialist early intervention services, and identification of those at high risk who may benefit from screening, treatment and management.
- Support earlier recognition of mental health problems and suicide risk.
- Knowledge and skills for the provision of personalised support for patients and carers in order to maintain the wellbeing of people with personality disorder.
- Managing those with multiple co-morbidities in the same individual, including combinations of physical and mental health problems.
- Improvement in the understanding and attitude towards people with personality disorder and their carers, and the reduction of stigma.

[22] The voluntary sector or community sector is the duty of social activity undertaken by organisations that are not for-profit

Training also provides reassurance to specialists that their primary care colleagues are competent to manage patients they return to primary care.

North Essex CCGs recognise the need for primary care practitioners to have opportunities to develop their skills in dealing with mental health or emotional problems, including personality disorder, and to support primary care practitioners in keeping up with the increasingly challenging and complex needs of a changing population.

To support this, provision of a structured, specific and targeted awareness and skills training will be provided to primary care practitioners. The training will primarily be aimed at helping early recognition of indications and risk factors for common mental health disorders including personality disorders, and will include the development of awareness and skills training for primary care teams.

Service users and carers:

In addition to developing educational programmes for general practices to help support them in their roles we will work with our specialist leads to promote education and understanding to those with a diagnosis of PD (including carers and families)and appropriate support. With knowledge comes empowerment; working with individuals to recognise signs and triggers to behaviour patterns and how to manage them can prevent crisis.

When a diagnosis is disclosed the information can give a sense of rejection and can have a significant impact on an individual who is already battling with the day to day challenges they are faced with. Almost all people feel better if they can start to get their lives in order. If someone has a PD this is more important and necessary to help them concentrate on leading an ordered and healthy life, through structured routines.

Health professionals need to work with each other and service users to ensure that the experience of a 'personality disorder' diagnosis moves away from its current stigmatising nature where individuals feel shame and worthlessness. To reduce this serious information problem, time needs to be given to service users, cares and families where a clear explanation of the diagnosis is given, where more relevant and accurate information is shared and people informed what their diagnosis means to them. Such conversations need to be held with the individual rather than without them.

Moving forward North Essex CCG's would expect to see the development of carers support and peer support networks incorporated into service provision.

Medication

As previously stated the use of medication is not recommended for PD as such (NICE guidance). Antipsychotic drugs should not be prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness (NICE CG078 recommendation 6.12.1.2)[23] and medication prescribed for more than four consecutive weeks should be reviewed.

The International Classification of Diseases; version 10 (ICD10) recommends that an individual should be assigned the PD diagnosis that best reflects their problems, rather than be given multiple diagnosis, Fourteen percent of the national sample looked at in 'prescribing for people with personality disorder' report (reference 11) had more than one PD diagnosis, perhaps reflecting the severity and complexity of some clinical presentations.

[23] http://www.nice.org.uk/Guidance/CG78

Through better understanding of PD we will improve assessment and diagnosis which we regard as a crucial area.[24] With better diagnosis of PD and the treatment models recommended, the levels of use of medication can be expected to fall.

Commissioners will work with primary care leads, pharmacy leads and Trusts to develop a proposal that will monitor the prescriptions of these medicines, moving towards a reduction in their use long term and so facilitating medication management support in the community.

Commissioning across the whole pathway

There is the potential to bridge this separation with collaborative commissioning and integrated care provision across the whole care pathway, both to improve the patient journey and to promote the best possible use of resources. This should include closer networking with all stakeholders and consideration being given to a more flexible approach to commissioning services reflecting the need for seamless transition across the whole pathway.

Within mid Essex two service users with PD were considered at Tertiary Referral Panel [25] in 2012.

One service user had already spent a number of months in a Psychiatric Inpatient Care Unit (PICU) but they were making very little progress. The other was someone who was on an open acute ward. As both appeared to be making little progress they had been identified as suitable for a Tier 4 PD service (services not funded by CCGs). However rather than a request for these individuals to be supported in Tier 4 services, a request was made for non-concurrent funding for additional psychological support for the service user and the staff team with a view to avoiding the use of an out of area placement.

Although the first service user remained on PICU progress was made in terms of managing the approach used by the staff team which reduced the levels of harm and challenging behaviours. The second service user was discharged to supported housing and supported by the additional psychological resource, through this support they have managed relatively well with some short admissions to manage crisis situations.

Both, in their way, can be described as successful insomuch that confidence amongst the team and outcomes for the patients.

North Essex adult mental health services are currently working closely with Children & Adult Mental Health Services (CAMHS) to develop seamless pathways for the transition between adolescence and adulthood. Currently if someone enters services at the age of 17 years they have found themselves victims of contract protocols, too old for CAMHS, too young for adult MH. This hurdle will be faced within future contract developments.

Initiative work with other agencies will look at other interventions that are not specifically done under the remit of the NHS yet are important in the prevention and management of personality disorders. This covers education, policing, social services, substance misuse, work in the community and across other public sector organisations and systems. It is therefore important that in the development, and indeed later on in life that these services are conscious of signs of psychological problems and behaviour and how to raise concerns and access appropriate care.

[24] Christiansen E, Larsen KJ.Child Psychol Psychiatry. 2012 Jan;53(1):16-25. doi: 10.1111/j.1469-7610.2011.02405.x. Epub 2011 May 12. Young people's risk of suicide attempts after contact with a psychiatric department - a nested case-control design using Danish register data.

[25] The Tertiary Panel acts as the gatekeeper of referrals and performance monitors all inpatient activity.

Influencing clinical policies and ethos

Health Professionals and services have an important modelling role; their approach should be person-centered, coherent, flexible, attentive and shared, supporting people to look after themselves more effectively. Honesty and integrity are important qualities in an effective and helpful professional.

Part of the work of PD services (given the prevalence of full blown PD, high levels of comorbity and high levels of individuals with personality difficulties) should be to influence the ethos and policies of MH services more widely.

Services should focus on:

- Up-skilling of MH workforce.
- Presence of PD champions.
- Dissemination of knowledge and experience.
- Training of key individuals in teams and wards.

Influencing specific provider services policies, especially:

- Admission procedures.
- Clinical risk management policies.
- Observation policies.
- Self-harm policies.
- Management of suicidal service users – separating long lasting and critical suicidality.
- Supervision, clinical/professional practice.

There needs to be better risk management of those who don't want to engage with services. Commissioners' call for providers to support individuals exiting services by being clear of what their expectations for them are; by giving service users the responsibility whilst being open and explicit. Through building local resilience individuals do not feel they are being pushed away and rejected. Access back into the services such as follow up appointments should be adapted to the individual's needs. This can reduce the number of 'non-attendees'.

Aspects of clinical services ethos which should be influenced are:

- Instilling greater use of psychosocial approaches.
- The maximisation of consistency across services.
- Integration of services.
- Robust and sophisticated risk assessment and management.
- Addressing clinicians' negative feelings about patients.
- Multidisciplinary working and decision making.
- A focus on dependency issues and autonomy.
- Increased use of assistive technology

It is recognised by north Essex CCGs that for a service to be effective it needs to be accessible and those individuals who access the services are valued. By evaluating access into current services north Essex CCGs will be able to identify the most efficient path for individuals and professionals. It is acknowledged that if there is more than one 'single point of access' individuals with PDs will contact all of them.

Section Six: Success Outcomes

A well-established PD outreach service will be accessible and available through a clear referral pathway which will be respected, knowledgeable, and supportive. Staff will feel supported; confident in their own skills, that there are resources beyond their own team / service available and be more satisfied with their work.

Those who have had to access services will feel included, listened to, taken seriously and feel in greater control of their treatment by having clear boundaries, consistent care, involvement in care planning leading to improved levels of recovery and functionality.

The predicted outcomes are:

- A more recovery model rather than a 'maintenance' model of care.
- Better and timelier discharge systems in place incorporating the use of technology.
- Reduction of PD prevalence on the acute wards.
- Reduction of bed days on the acute wards.
- Improved staff morale and a reduction in staff sickness.
- Increase in knowledge of and attitude to PD in providers of services / service users / carers /families / communities.
- Improved service users /carers / families / satisfaction.
- Reduction in Section 136 usage, i.e. improved liaison with police / improved PD knowledge for police.
- Reduction in suicide rate.
- More focus on physical health in mental health in order to improve healthy life expectancy.
- Increase in discharges to the GP.
- Reduction in admission to A&E and urgent care services.
- Increase in clarity about appropriate care pathways for PD.
- Better interface between primary, secondary & acute care.
- Better interface between children, adult and specialist commissioning.
- Increase in recovery based services; including self-care management.

APPENDIX ONE

Diagram One: North Essex Stepped Model of Care – taken from the North Essex Mental Health Joint Commissioning Strategy for Adults (2014 – 2017)

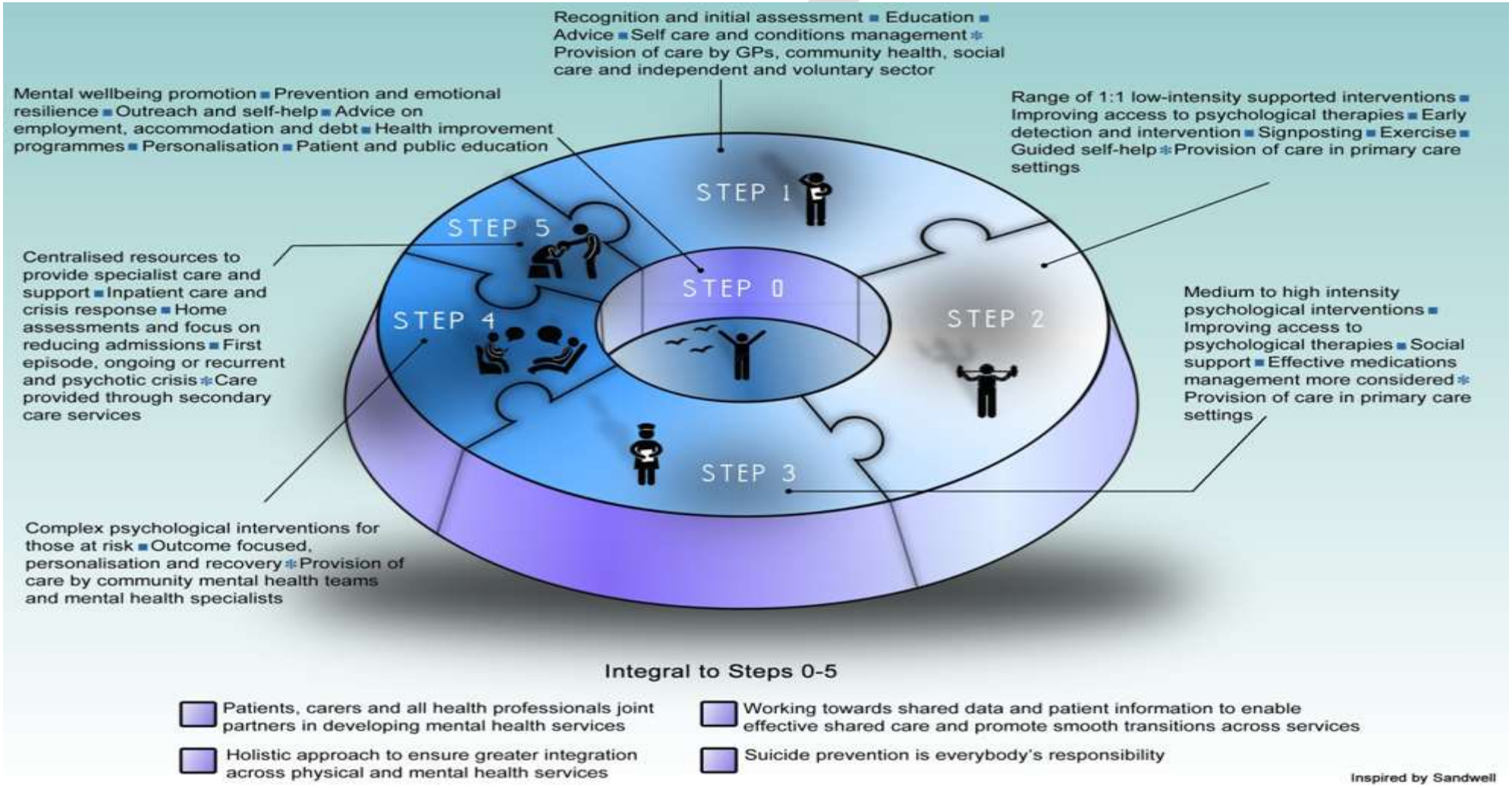
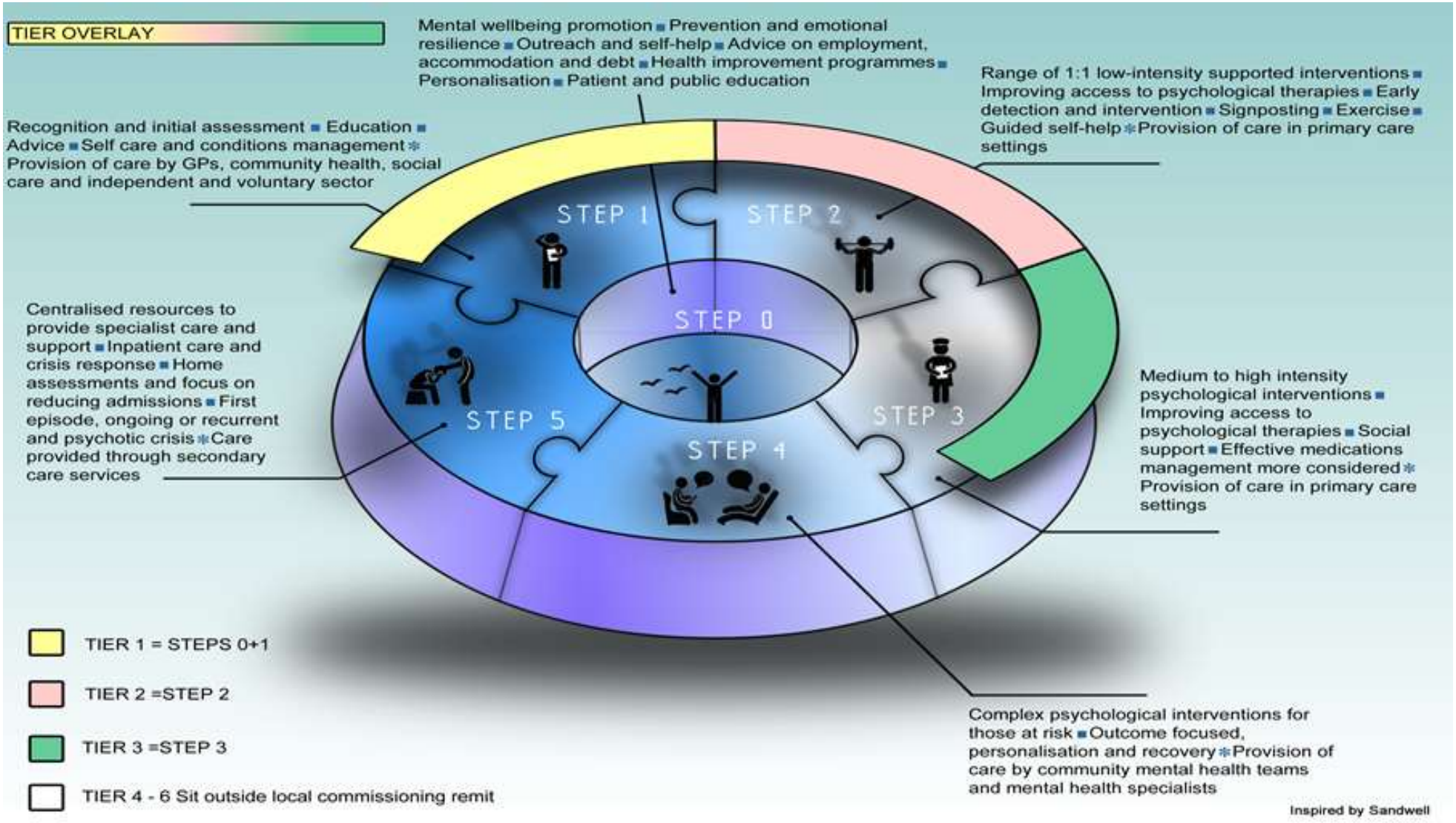


Diagram Two: Aligning the tiered PD model to the North Essex Model of Care.

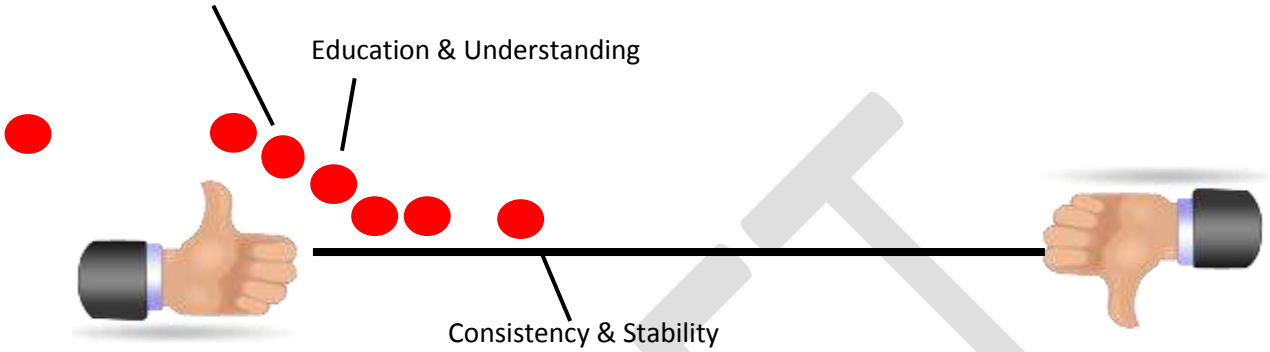


APPENDIX TWO

Service User Engagement and Focus Group – Personality Disorder Strategy. Dec 2014

When asked 'How happy are you with the services you receive?'

Treatment specific



Respect

Two way process

Collaborative

'Practice what you preach' – Policies

No therapies in area

What does Personality Disorder mean to you?

Rejection

STIGMA

- Understanding
- Inconsistent
- Staff (i/c GPs)
- Public
- Mis-understanding (public people)
- **ALL**
- 'Palmed off' with diagnosis

INCONSISTENCY

- Structure
- Life
- Services
- Choice? i/c carers

Rejection

Isolating

- Self-community

CONFUSING

- Person
- Work
- Community
- Different experiences
- **"How did I get here?"**

Complex

Complex

- Inconsistent
- Life
- Services
- Understanding
- **'LABEL–PD'**

Emotional - Instability

Tortured Soul

North Essex Personality Disorder Strategy - Adults

What would be your Ideal Outcomes?

- Inclusion

- **UNDERSTANDING**
- To be understood

- Acceptance
- Accept ourselves to move on

- Holistic
- 'All of Life'
- All the person not symptoms
- Life long journey
- HEALING

- 'To stop existing & support to start living'
- Realise potential
- Not feeling isolated
- Rediscover self

ACCEPTANCE

- Understand 'ME'
- Maintain & understand longer
- Early recognition of signs/triggers
- Prevent crisis

- By the world
- Lead to managing 'problem'
- Long term management

- Future
- To be proud of
- Fed up with feeling ashamed

- Empowerment
- 'not to be treated like a muppet'
- Trust ourselves
- Know the triggers
- Be given the right tools

TRUST

- Be believed in

HOPE

What are the barriers in reaching these outcomes?

COMPREHENSION

- Being understood
- Difficulty expressing
- ONE SIZE FITS!!
- No encouragement to widen life skills

- Myself
- Understanding of anything good
- Low self-esteem
- Lack of confidence
- Motivation
- Frustration **COMPLEX**

- Work (self & services (Psychiatrists)) **ACCESS**
- Flexible access to services
- Creativity (lack of)
- 9 – 5 !!

- Feeling of hopelessness
- Fear of failure

- Poor communication
- Lack of communication
- Continuity between/across services
- Fragmentation

- NHS myopia **PIVOTAL**
- Short-termism
- Lack of understanding/tolerance in MH services & other services (eg Acute/Primary care)
- Faulty attitudes - clinicians

- Expectations

CONTINUITY

- Positive reinforcement
- Lack of support
- Managing to keep the things I have learnt at the Haven

- £ **COMMISSIOINING**
- Lack of funds
- Service re-design
- No expert service locally

- Haven closing
- NOT getting to the Haven and getting the help I need before its closing

- Families
- Denial

What would help tackle the barriers and reach the outcomes?

RELATIONSHIP

- Realistic expectations (self)
- Faith in services
- Self – belief

ACCESS CONTINUITY

- Better structure to services
- Empathy from services
- Understanding
- Belief
- Person centred service rather than service for a 'label'
- 24hr access to support
- Joined up services
- Continuity of support
- Excellent communication

EDUCATION

- Greater understanding of PD
- Public Meetings (eg world mental health day)
- Presentations to GPs/PPG/WI

EMPOWERMENT

- Fighting for yourself
- Become a Trust governor
- Campaigning for what you believe in

COLLABORATION

- Honesty
- Be yourself
- Trust each other

COMMISSIOINING PIVOTAL

- Money for mental health
- Joined up services
- Creativity
- Permission to be innovative with services
- £

BEING HEARD