# NHS Lanarkshire Personality Disorder (PD) Strategy Group Proposal

*Summary prepared by Lucy Macintyre & Stephen Davidson (co-chairs) on behalf of the PD Strategy group, December 2024*

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## 1. Background to the NHS Lanarkshire PD Strategy Group

- The NHS Lanarkshire Personality Disorder Strategy Group was set up in 2019 in response to recommendations from 2 key documents:

  i) Royal College of Psychiatry report on PD in Scotland (2018)
  ii) Mental Welfare Commission Report (2018)

- The current NHS Lanarkshire "Borderline Personality Disorder / Complex Trauma" Integrated Care Pathway was created in 2012, and required updating in light of national recommendations made by the above publications.

- The group was initially chaired by Dr Liz Ogston (Consultant in Medical Psychotherapy). Following Dr Ogston's departure in summer 2023, the group was chaired by Dr Lucy Macintyre (Consultant Clinical Psychologist) and then co-chaired between Dr Lucy Macintyre & Dr Stephen Davidson (Consultant Forensic & General Adult Psychiatrist) from December 2023.

- The aim of the group was to review the current provision of services for people who might attract a diagnosis of PD and develop a coherent care pathway to update the current Integrated Care Pathway (ICP).

- The PD Strategy Group grew to a membership total of 38 staff in October 2024 reflecting the level of interest in this area. Membership has been made up of staff from across all mental health services (including Forensics, Older Adults, CAMHS, Addictions, PLNS, Psychotherapy, High Resource User Group, Inpatient services, CMHTs, and TESS). More recently there has also been representation from MHOs. A variety of professions and localities have been represented.

- The group met quarterly, initially in person, but with the onset of Covid restrictions in 2020, all meetings were held on MS Teams.

- The group initially provided highlight reports to both the Adult MH Clinical Quality Group and the MHLD Adult Clinical Governance Committee, but it was established in 2024 that it was only necessary to feed back to the latter.

## 2. Summary of the activity & core recommendations of the PD Strategy Group:

| What we wanted to find out | What we did | Outcome |
|---|---|---|
| What services are being provided for people with PD across NHSL? | Scoping exercise across NHSL services | A variety of approaches offered, with localised expertise but no co-ordinated / systematic approach, creating an internal 'postcode lottery'. |
| What training is available to staff? | Scoping exercise of current and past training, including workforce census | Evidence of good training offered but localised & inconsistent. Little training completed in specialised approaches. No overall co-ordination and not always evaluated. |
| What are the views of those with lived experience? | Partnership project with the Scottish Recovery Network (SRN). Over 70 people (with LE, their family / carers / 3rd sector workers) engaged with project looking at what service pathway might look like. | Heard the views of people with lived experience outlining a desire for a trauma-informed, person-centred, & whole system approach with peer support involvement. |
| What are other Health Boards doing? | Met with the 10 other mainland HBs to find out. NHS Fife & service from Hertfordshire invited to meeting to present on their experiences of implementing SCM | Discovered a variety of PD service provision. Some with specialist PD services, most without. Emulated some of these models in PD service recommendations. |
| Are there any national organisations/guidance to link in with? | Regular contact and liaison with the Health Improvement Scotland PD Improvement Programme for guidance. Contacted Scottish PD Network. | Presented SRN partnership work at PDIP national webinar. Had been offered role as pathfinder board for next phase of PDIP work (declined by NHSL senior management due to other significant service development). Co-chairs of group attended SPDN conference in June 2024. |

### CORE RECOMMENDATIONS OF THE PD STRATEGY GROUP

1. IMPLEMENTATION OF STRUCTURED CLINICAL MANAGEMENT PATHWAY BASED ON NHS FIFE MODEL
2. CO-ORDINATED AND FUNDED STAFF TRAINING FOR ALL MENTAL HEALTH STAFF.
3. LIVED EXPERIENCE INVOLVEMENT IN STAFF TRAINING, DEVELOPMENT AND DELIVERY OF CARE
4. PATHFINDER SITE FOR HEALTH IMPROVEMENT SCOTLAND PD IMPROVEMENT PROGRAMME.

### 3. Why do we need an NHSL PD Pathway?

NHS Lanarkshire produced an Integrated Care Pathway (ICP) for "Borderline Personality Disorder / Complex Trauma", (NHS Lanarkshire, 2012), which has not been applied systematically across NHSL services and was in need of review. The following issues have been highlighted by the work of the PD Strategy Group when considering the need for a pathway:

*Estimated population affected*

- Estimates of PD in the general population vary widely (1.8%-22%). One study of large British population by Coid et al (2006) found a prevalence of 4.4% in the community.
- Estimated working age population in NHS Lanarkshire: 389,306 (63% of 617,946 total population)
- Estimated prevalence of PD in working age population in NHSL: 7,008 (conservative estimate based on 1.8% prevalence for BPD) – 23,358 (liberal estimate based on 6% prevalence for all PD)

*Cost*

- The business proposal for an NHSL PD strategy will focus on cost avoidance (reducing repeated contacts with scheduled & unscheduled care and potential reduction in use of Out of Area placements). Anecdotal reports from PLNS (and other services) cite considerable resources used for people with PD difficulties.
- Data from NHS Lanarkshire High Resource User Project (presented Feb 2024): [*Detailed financial ananlysis has been redacted*] **41% of high resource users in these cohorts had PD related difficulties**
- NHS Lanarkshire Out of Area placements (presented Apr 2024): 8 individuals identified as currently on an Out of Area placement with a personality disorder as part of diagnosis. Approximate cost of these 8 patients to NHSL to date: ~~**£6.2M**~~

*Reputation*

- From meetings with each of the other mainland health boards, **only NHS Lothian offered less treatment options for PD alongside NHS Lanarkshire when compared with other mainland health boards**, highlighting NHSL as an outlier in service provision.
- The contrast is even more stark when comparing to services provided in England where the majority of NHS Mental Health Trusts offer both dedicated personality disorder services (**84%**) and generic services (**91%**),
- NHSL MH, LD & Addiction Services' completed SAERs involving suicide / homicide (or near miss of same) 2020-current: [specific SAER numbers redacted]

*Views of those with Lived Experience*

- Engagement with the voices of Lived Experience through partnership work with the Scottish Recovery Network highlighted the importance of involving people with lived experience in the design and, where possible, the delivery of services. The SRN work highlighted a desire for the following:
  - **Genuinely trauma-informed care**: Collaboration, humility, responsiveness, and a sense of safety when engaging with services. Avoidance of re-traumatising people when accessing support.
  - **A truly person-centred approach**: support whilst waiting for service input, not being labelled as problematic, actively seeking to reduce stigma & discrimination
  - **A whole person, whole system approach:** choice, flexibility, options, linking in with non-NHS services.

Workforce Expertise

- A census was completed examining the experience of our existing NHSL workforce in providing psychological therapies for those with PD (August 2024).
- Safety & Stabilisation training has been completed by more than half of the workforce and this training is ongoing as part of the National Trauma Framework.
- In general, formal training in other modalities is far less common. Formal training in cognitive-based approaches (CBT, CAT, SFT, behavioural activation) is more common than in other evidenced-based modalities for PD (DBT, MBT, STEPPS).
- This outlines practical limitations with regards to roll out of a modality which has strict governance with regards to training and accreditation, in addition to the availability of supervisors in our existing workforce.
- **Staff regularly report lack of knowledge/confidence in working with people with PD difficulties.** There has been no overall co-ordination of staff training for working with people with PD in NHSL.
- There has been a variety of PD related training delivered to staff in NHSL over recent years in a variety of settings. Formal and informal evaluation suggests that this was well-received and valued by the staff attending.
- The type of evaluation of training has varied and only one service provided formal follow up on promoting skills implementation through coaching sessions.

**4. Determining a model of treatment**

- There are a variety of treatment options outlined for Personality Disorder (PD). No medication is licenced specifically for the treatment of PD but medications are used for specific symptoms/co-morbidities.
- The Matrix (NES, updated 2014) lists several evidence based psychological therapy approaches for "Borderline Personality Disorder" (the updated evidence base for the Matrix is due out by the end of 2024). These include Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), General Psychiatric Management (APA style), Mentalisation Based Therapy (MBT), Schema Focused CBT, Systems Training for Emotional Predictability & Problem Solving (STEPPS), transference focused psychotherapy, and mentalisation based day hospital.

- The Matrix also states that General Psychiatric Management (McMain et al., 2009) and Structured Clinical Management (SCM) (Bateman & Fonagy, 2009) are as effective as DBT or MBT.
- SCM was introduced to reduce bias for specialist interventions vs. TAU in research post-2006 (SCM demonstrates equivalent effects to other specialist intervention after correcting for publication bias)
- From meetings with each of the other mainland health boards, we established that a variety of different psychological treatments were provided nationally including DBT, MBT, SCM and STEPPS.
- **NHS Dumfries & Galloway and NHS Fife had prioritised SCM (Structured Clinical Management), due to the model being more flexible (for patients / staff / services), cost-effective (for patients and staff training) and durable (to staff loss)**.
- With this in mind, and given the current climate of financial constraints within mental health services, the PD Strategy Group agreed to investigate SCM as a potential pathway.

### *4.1 What is Structured Clinical Management?*

- Created to standardise non-specific factors from specialist psychological therapies to make more reliable comparisons of treatment efficacy in research.
- Based on the "5 C's": Coherence of model, Consistency of delivery, Collaborative, Continuity over time, Communication and reciprocity.
- Enables generalist, non-specialist mental health practitioners to deliver care using a structured, organised, and recovery-focused approach.
- Involves individual and group approach in a time frame of 12-18 months.
- Problem solving approach with focus on therapeutic relationship.
- Includes safety planning and crisis management.
- Could bridge the gap for those with moderate PD and/or difficulties with consistent engagement.

### *4.2 Why Structured Clinical Management?*

- Can provide an evidence based (Cochrane, Matrix, NES) unifying model and a core set of principles and skills across localities.
- Resolves current issue of patchwork approaches depending on staff expertise/training, providing clear direction to both practitioners and service users.
- Avoids an approach to care that is unstructured and crisis-driven; and where the therapeutic approach is influenced predominantly by the orientation of the practitioner offering individual sessions.
- Can be provided in generalist mental health service setting in the absence of a specialist service (or can work alongside a specialist service should funding allow the establishment of such a service).
- Requires less additional and stringent staff training than traditional PD approaches like DBT / MBT, therefore is more cost-effective and durable.
- Provides more flexibility in how treatment is delivered and can be adapted to local services more readily than traditional PD approaches like DBT / MBT.
- Evidence of effectiveness (once publication bias factored in, equivalence of effect with specialist approaches like DBT / MBT). Will be included in updated Matrix guidance for Borderline PD (awaiting publication).
- Evidence of successful implementation in other NHS Scotland HBs (NHSD&G / NHSF) as well as in services in England and Europe.

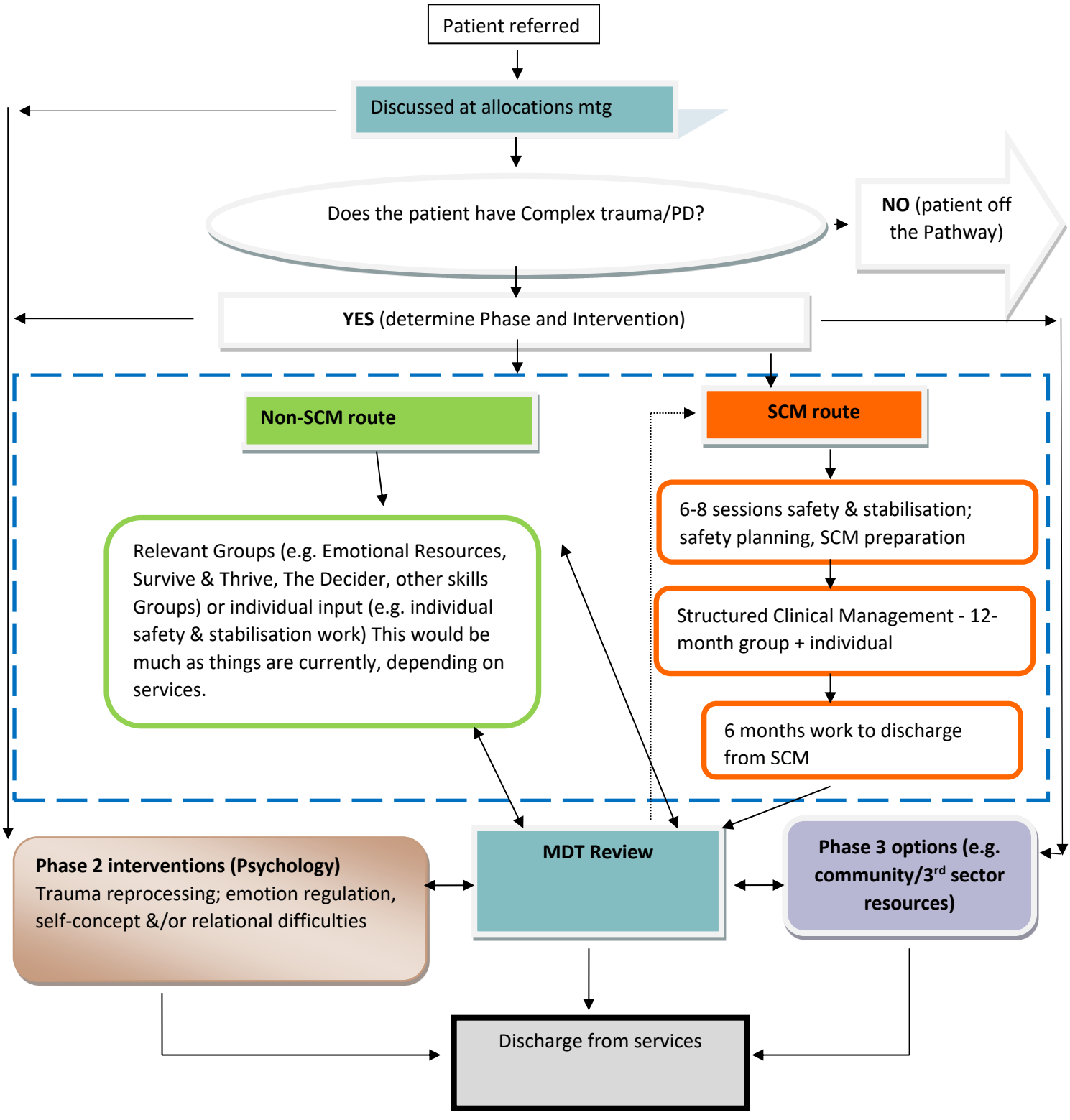
## 5. Core Recommendations of the PD Strategy Group

### 5.1 Implementation of Structured Clinical Management Pathway

**Proposed Model for NHS Lanarkshire**

Implement similar SCM pathway as the NHS Fife PD / Complex Trauma pathway with a stepped-care approach.

**DRAFT NHSL Pathway for patients with Complex Trauma / Personality Disorder**




**The Decider: basic skills in emotion regulation, distress tolerance, interpersonal effectiveness, Mindfulness

*Non-SCM route:*

- Similar to current service set up.
- Safety & Stabilisation type individual or group input (e.g. Survive & Thrive / Emotion Resources Group / DBT Skills Group / Decider Skills Group (where available). Duration 8-12 weeks.
- Where appropriate, referral on for various 1:1 modalities matched to patient needs including specialist interventions where they exist (CBT/ CAT / DBT / MBT / SFT) delivered predominantly by psychology / psychotherapy services. There is scope for future innovations here as resources allow. Current waiting times for this input high due to demand v capacity.

*SCM route:*

- Patients would be referred within CMHT, following discussion at team caseload meeting as part of new model for general adult mental health services.
- Module 1: problem solving / mindfulness / mentalizing. 1:1 treatment (delivered by CMHT staff; duration 6 months; 60 minutes/week).
- Module 2: emotional regulation and mood management skills.
- Module 3: impulsivity / self-harm / suicidality
- Module 4: relationship skills / mentalizing attachment (open group treatment containing 8-10 patients per group with programme of rolling modules; delivered by nursing / junior psychology; duration 18 months; 90 minutes/week).
- Possibility of patients being closed to Duty Service in CMHT while involved in SCM (as in Fife model, however this would need to be worked out based on capacity). Instead they would have access to SCM-based clinicians, preferably their keyworker if available.
- Patients remain on CMHT team caseload with named keyworker (in Fife, individual is held by the SCM service & not held by the CMHT so this could also be considered).

***Practical considerations for SCM Pathway***

Development of ICP

- Agreement of roles and responsibility of keyworker and SCM practitioners
- Agreement of roles and responsibility of CMHT monthly caseload management meetings.
- Consideration of lived experience involvement (e.g. peer support workers)
- Creation of referral criteria and forms
- Agreement of assessment, diagnosis and formulation process.
- Development of crisis plan and safety plan framework.
- Agreement of processes for the management of endings, discharges and transitions
- SOP regarding crisis care, admissions and the role of inpatient teams.
- Guidance regarding prescribing in PD.

Development of SCM intervention

- Development of tailored SCM manual utilising components from main and NHS Fife SCM manuals, in addition to material from DBT, Decider, MBT and STEPPS.
- Staff training programme which matches the basic skills of the workforce that will deliver the intervention (training census) and meets the needs of our patient population (involvement of people with lived experience), in line with section 2, “Staff Training” below.
- Review of nursing and psychology job planning, in co-ordination with CMHT/PTT integration with general adult mental health services development.
- Consider CMHT buddy system to pool resources (Group 1: North / Airdrie / Coatbridge; Group 2: Bellshill / Motherwell / Wishaw; Group 3: Clydesdale / East Kilbride; Group 4: Hamilton / Camglen).
- Agree programme of clinical supervision which must be protected and regular. This could be delivered remotely and part of a buddy system.
- Development of process to monitor fidelity of intervention via audit process which may involve triangulated approach of recording of sessions and collation of staff / patient feedback.

### 5.2 Staff Training

- Future training needs to be strategically linked, co-ordinated and needs-led. This could potentially be delivered in a tiered system similar to the National Trauma Framework.

- A standardised training programme for all mental health staff (relevant sections could be added for specific services as needed). This could be modelled on the NHSGGC Co-ordinated Clinical Care (CCC) training (an example of good practice on PDIP website) which forms the foundation to the BPD Pathway in NHS GGC. NHS GGC employ 0.4 FTE Band 7 staff to train all mental health staff on a rolling programme. The training aims to:
    - Introduce core knowledge and skills as the foundation for the pathway to improve the quality of general psychiatric care.
    - Create a common model for good practice across all services.
    - Improve consistency of patient experience no matter where the service is accessed.
    - Promote a culture of empathy, optimism and hope.
    - Contribute to the board's Mental Health Strategy aim of reducing in-patient bed use by improving responses to crisis and out of hours' contacts.
    - Provide the opportunity to share information about the pathway and stepped/ matched care options.

- Development of a Learnpro / Turas module may be appropriate +/- possibility of linking this with standardised face-to-face training. (The current Turas module "Working with PD offenders" focuses on PD and offending).

- Many people with personality difficulties/ disorders will have a history of trauma so all mental health staff should complete the Turas module "Developing your trauma skilled practice". This module is designed to increase understanding of what psychological trauma is and how to support recovery.

- Inclusion of in-house MBT skills training to promote the "curious/validating" stance of practitioners.

- Staff training including the four modules of SCM according to bespoke manual and basic group facilitation skills (NHS Fife have kindly shared their SCM resources for this). Staff training must be delivered as part of protected training and development time.

- Any staff training would benefit from the involvement of people with Lived Experience in its design and delivery. Further down the line, this might involve individuals who have been through SCM (potentially in a peer support worker capacity).

### 5.3 Involvement of People with Lived Experience

- During the co-design phase of the partnership work with the SRN, the following suggestions were made by participants:
    - **A collaborative & holistic approach to care planning document:** collaborative creation of a holistic care planning document.
    - **Integration of peer navigators** into mental health services to support people accessing services by linking them with complementary support in the community. The navigators will work with the person to agree goals, identify what support is needed, and develop a care plan together.
    - **Training that is co-produced & co-delivered** by people with lived experience and NHS staff. Focus on understanding of trauma, managing crisis presentations, role of staff burnout / compassion fatigue, staff wellbeing and emotional resilience.
    - **Drop-in wellbeing hub:** hosted by NHS Lanarkshire in partnership with local third-sector organisations to offer a variety of emotional, practical, and social support with inclusion of peer workers.
- NHSL Psychological Services have set up a Lived Experience Interest Group which is looking at options of how to meaningfully incorporate people with lived experience into all aspects of psychological

services provision. This group could potentially contribute to involvement of Lived Experience in the PD pathway.

- Explore engagement with third sector organisations to develop a complementary programme of psychosocial interventions and inclusion within all localities.

### 5.4 Pathfinder Site for Health Improvement Scotland PD Improvement Programme

- The Personality Disorder Improvement Programme (PDIP) completed Phase 1 of the project in March 2023. The PDIP was due to launch Phase 2 in February 2024 but this was instead delayed until September 2024 under the new Reform Programme.

- At the end of Phase 1, the PDIP group outlined the possibility of working with "pathfinder boards" in relation to services for people with PD type difficulties. The NHSL PD strategy group informed the leads for the PDIP that NHSL would be keen to be involved as a pathfinder board and following a meeting with the PDIP team in July 2024, with MDT representation from NHSL, **we were offered the opportunity to become a pathfinder board, pending approval by NHSL senior management**.

- The Memorandum of Understanding between NHSL and HIS would have stipulated commitment to each other, with HIS supporting and facilitating the work with an expectation that NHSL would:
    - Engage in the coaching sessions (monthly)
    - Regularly collect data (and this will include developing and testing a data set)
    - Engage with service design/QI work
    - Engage with lived experience and third sector
    - Develop peer support network
    - Grow staff education

- Unfortunately, this offer of support was declined by NHSL senior management due to other significant service developments within general adult mental health services. If there were a reversal of this decision or we could be included as a 'pathfinder board' at a future date, **this would limit the burden on existing members of the PD Strategy Group leading on extensive service development in the absence of additional internal resource for the same** (NHS Tayside have employed a full time Band 8d to oversee PD service pathways there).

- Services which have implemented SCM pathways in their areas (described in "SCM for Personality Disorder: An Implementation Guide") outlined the **importance of staff having clear roles and protected time dedicated to pathway work**. The following key "governance enablers" are also described:
    - Governance board for monitoring the pathway
    - Engagement with service users in governance
    - Regular internal & external training
    - Supervision system
    - Audit process
    - Personality Disorder policy/procedure (e.g. pathway, guidance, SOPs)

- In the absence of support from HIS as a 'pathfinder board', utilise external support from organisations including SPDN, NHSD&G, NHS England and NHS Fife, who have experience of developing an SCM pathway within their service.

- This summary of recommendations from the PD Strategy Group concludes the aims of the group and, in the absence of any next steps with regards to a pathway, no further meetings have been planned. It is the hope of the group that a pathway will be developed in future and the activity of this group will be useful in informing this process.

## 6. References:


- MWC report, 2018: *Living with BPD: The experience of people with the diagnosis, families and services in Scotland.*

- RC Psych report, 2018: *PD in Scotland: raising awareness, raising expectations, raising hope.*

- Coid J, Yang M, Tyrer P, Roberts A, Ullrich S. Prevalence and correlates of personality disorder in Great Britain. Br J Psychiatry. 2006 May; 188:423-31. doi: 10.1192/bjp.188.5.423. PMID: 16648528.

- McMain S.F., Links P.S., Gnam W.H., Guimond T., Cardish R.J., Korman L., et al. (2009) A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. American Journal of Psychiatry, 166, 1365–74.

- Mitchell, S.; Sampson, M; & Bateman, A. (2022) Structured Clinical Management (SCM) for Personality Disorder: An Implementation Guide. Oxford University Press. Personality disorder services in England: findings from a national survey. BJ Psych Bull. 2017 Oct; 41(5): 247–253.

- NHS Education for Scotland. (2023, November). 'The Matrix: A guide to delivering evidence based psychological therapies and interventions in Scotland'. Retrieved December, 2024, from **https://www.matrix.nhs.scot/**

- Storebø OJ, Stoffers-Winterling JM, Völlm BA, Kongerslev MT, Mattivi JT, Jørgensen MS, Faltinsen E, Todorovac A, Sales CP,Callesen HE, Lieb K, Simonsen E. Psychological therapies for people with borderline personality disorder. Cochrane Database of Systematic Reviews 2020, Issue 5. Art. No.: CD012955Cochrane https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012955.pub2/epdf/full