West London Mental Health NHS Trust

Working with Personality Disorder – Building Resilience

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Promoting hope and wellbeing together

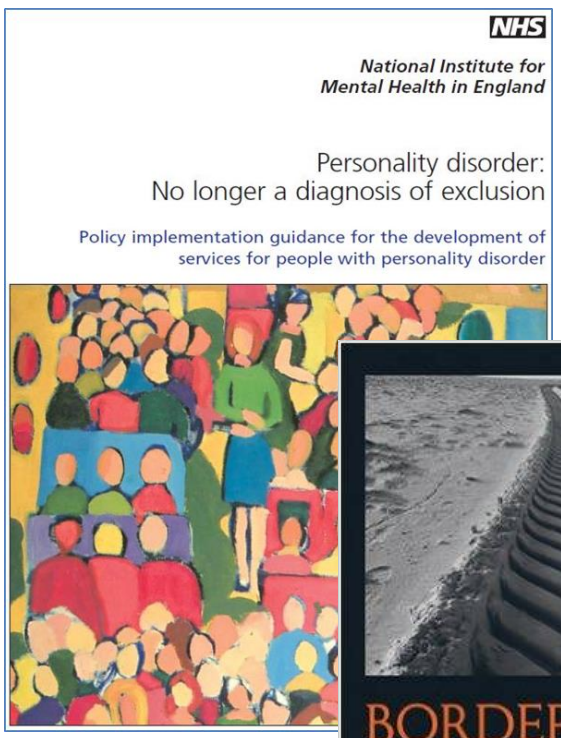
Today

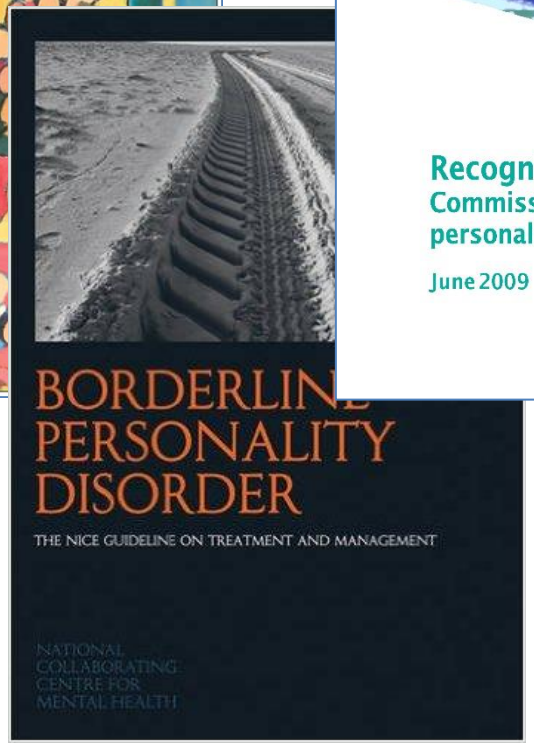
- Concept of personality Disorder
- Challenges of working with patients in acute distress
- Concept of Resilience
- Working with PD to enhance resilience

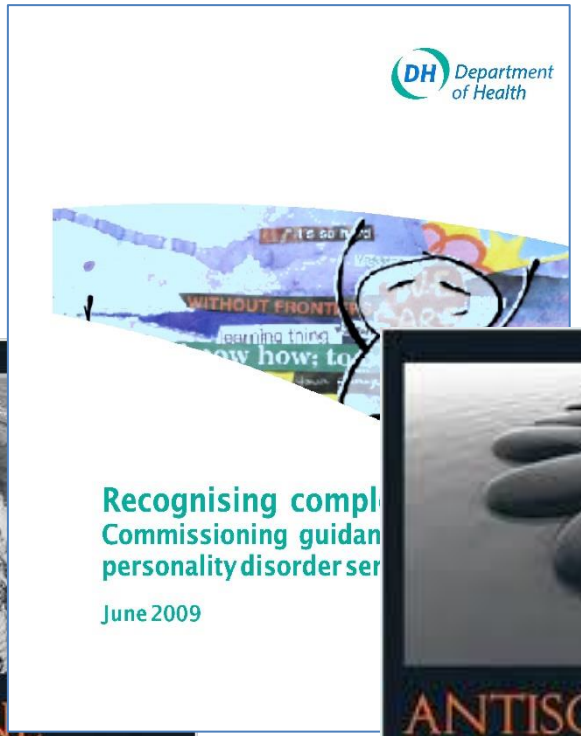
Question

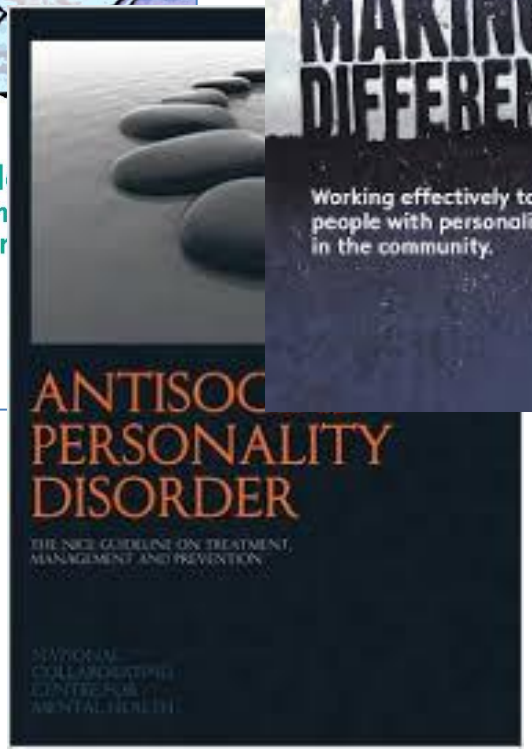
What do we mean by personality disorder?

Personality Disorder









Some Salient Characteristics

- Difficulty in establishing and maintaining caring relationships
- Confusing approaches to help-seeking
- Poor sense of identity
- Poor psycho-social resilience
- Marked impulsivity
- Comorbodities are common and often precipitate presentation (Eating disorder, Substance misuse, mood disorder etc)
- ALL our patients have disturbed relationships

Prevalence

- 4.4% in community
- 24% of consecutive attendees in primary care?
- 33% in psychiatric outpatients
- 50% in psychiatric inpatients

Impact on Health

- 17.7 years of life lost for Men,
- 18.7 years of life lost for women
- 9% die by suicide
- 45% presenting to A&E with self-harm have personality disorder
- Doubles the risk of “poor outcome” in depression
- Doubles the risk of “high use” inpatient services

A note on “Severity”

- ICD 11
- Can be quantified
  - Diagnosis
  - Pervasiveness
  - Complexity
  - Risk
  - “Manageabiltiy”
- Need to get away from “categorical” approach

Severity Questionnaire

Name Date completed

PLEASE CIRCLE THE SCORE FOR EACH OF THE FIVE ITEMS
0 = Absent
1 = Present (to moderate extent)
2 = Present (to considerable extent)

1. Diagnosis

There are ten Personality Disorders outlined in the DSM-IV (APA, 2000). These diagnoses are organised according to three clusters;

Cluster A – Odd/ Eccentric (Paranoid, Schizotypal, Schizoid)
Cluster B – Dramatic/ Emotional/ Erratic (Borderline, Histrionic, Narcissistic, Antisocial)
Cluster C – Anxious/ Fearful (Obsessive-Compulsive, Dependent, Avoidant)

0 = No formal diagnosis may have been made, or a single diagnosis or diagnoses present in only one cluster, not including ASPD. Equates to approximate IPDE screening tool score < 30.

1 = More than one PD diagnosis, probably in more than one cluster, unlikely to include ASPD. IPDE screening tool score approximately 30 – 50.

2 = Multiple PD diagnoses in more than one of the three clusters, and may include ASPD. IPDE screening tool score usually > 50.

2. Pervasiveness

If an individual is severely affected by PD, then this will be evident across many domains of life functioning:

Relationships –intimate, familial, social
Activities of daily living eg. self care, shopping, cleaning, home management, paying bills
Living conditions
Occupation
Education
Social functioning

0 = Little significant impact on functioning, and normally able to function effectively eg. stable living arrangements, social participation, able to work, evidence of some good relationships

1 = Functioning moderately impaired; some evidence of adequate functioning but for short-lived periods of time eg. predominately dysfunctional relationships, frequent job changes/periods of unemployment, difficulties with daily living tasks,

2= Functioning is seriously impaired across many domains, and lifestyle is severely disrupted or never established eg. unstable/unsuitable living conditions, or homelessness, inability to establish and maintain relationships, social exclusion, unemployment, financial insecurity,

Emotional challenges of PD

- As a disturbance of relationships, the emotional effect on staff is pronounced:
  - Intense emotional states = exhausting
  - Emotional instability = unpredictable
  - Identity Diffusion = difficulty in connecting
  - Violence to self and others = trauma, fear
  - Psychic defence vs excitement = anger
  - Primitive Defences = confusing, fragmenting

So is it any wonder?

Demystifying "PD"

- Everyone feels incompetent when it comes to managing PD
- The difference that divides PD services from generic ones is that the staff are interested - "culture of enquiry"
- Teams which allow staff to safely unpack experiences turn what is unpleasant into something very rewarding

Question

What are the particular challenges posed by personality disorder within a PICU or Low Secure Setting?

Particular challenges

- Email poll, conversations with colleagues
- What are the top challenges?
  1) Managing the team's feelings towards the patient
  2) Managing Aggressive Behaviour without resorting to medication, seclusion and restraint
  3) Using Psychological approaches in a PICU environment
  4) Difficulty in articulating treatment goals
  5) Difficulty in identifying care pathways

Resilience

- “The capacity to recover quickly from difficulty”
- “adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress”*

*American Psychological Association

Factors that build resilience for the individual*

- Capacity to make realistic plans
- Confidence, positive self regard
- Communication and problem solving skills
- Capacity to manage strong feelings

*American Psychological Association

Factors that build resilience for the TEAM

- Capacity to make realistic plans
- Confidence, positive self regard
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Using the language of Mental Health

- Clinical Leadership
- Effective assessment
- Effective Multi-disciplinary working
- Engaged patients and carers

Establishing a collective formulation and approach and then communicating it to every one

Formulation brings:

- Improved Quality of Care
- Enhanced Risk Assessment
- Enhance empathy and understanding
- Re-humanise staff and patients
- Manage anxiety

In WLMHT - Challenges re PD

- Lack of understanding, institutional stigma
- Low skill base
- Clinicians Lacking confidence
- Variability in capacities, attitudes, beliefs
- Fragmented services
- Idiosyncratic practices
- Limited reflective practice
- Frustratingly – also a lot of expertise!

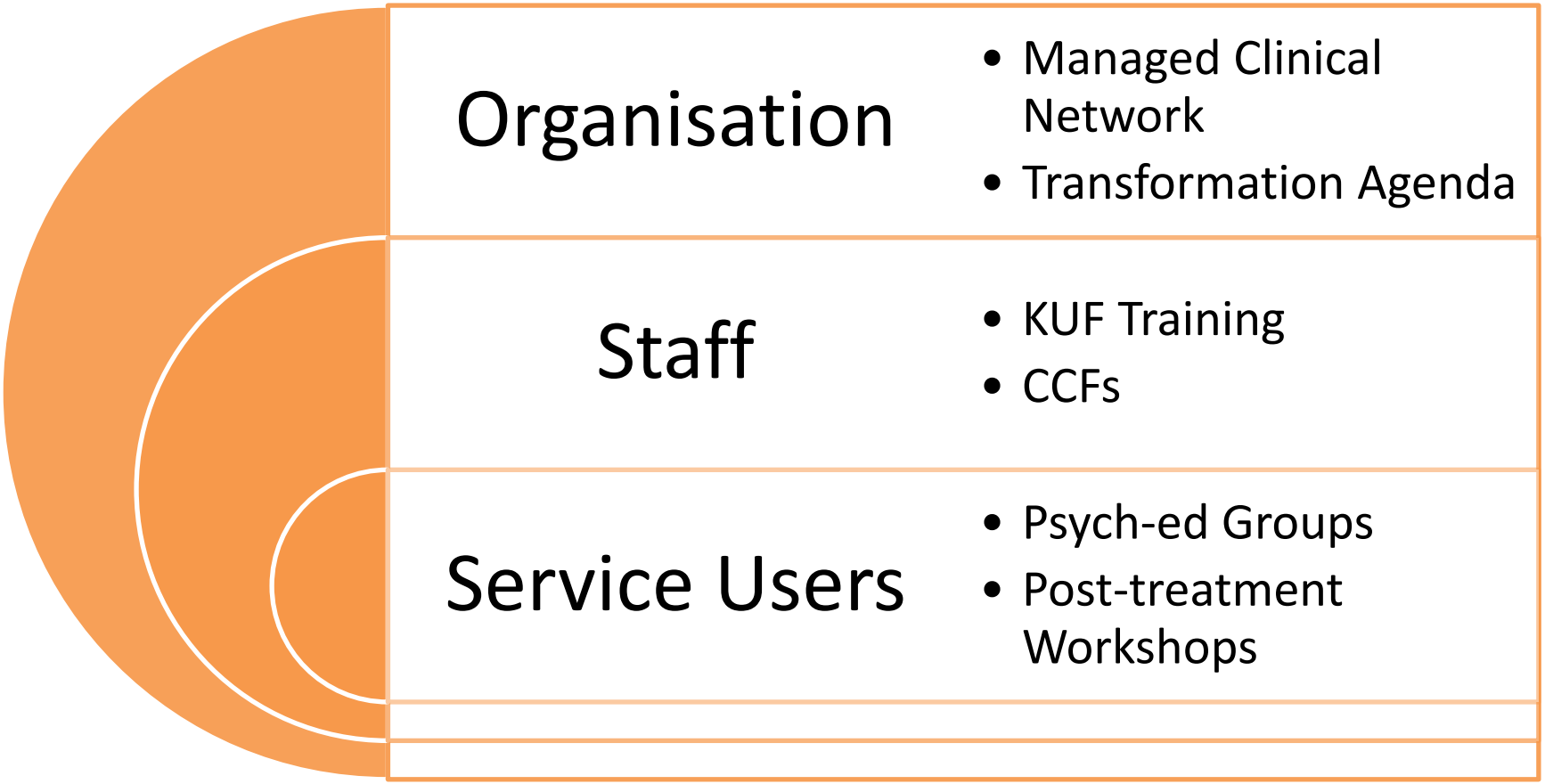
Establishment of Managed Clinical Network

- Budget £131K pa
- Trustwide service
- Co produced with emergence
  - Trained 659 people in KUF so far…
  - 11 ½ day conferences
  - 5 Recovery College courses
  - 3 x10 week psyche-ed per year (3 years)
  - 10 Team development packages
  - 12 Complex Case forums across trust

3 key principles

- Everything we do is coproduced
- We seek to promote an MDT approach
- We seek to promote all therapeutic modalities

Whole Systems Approach

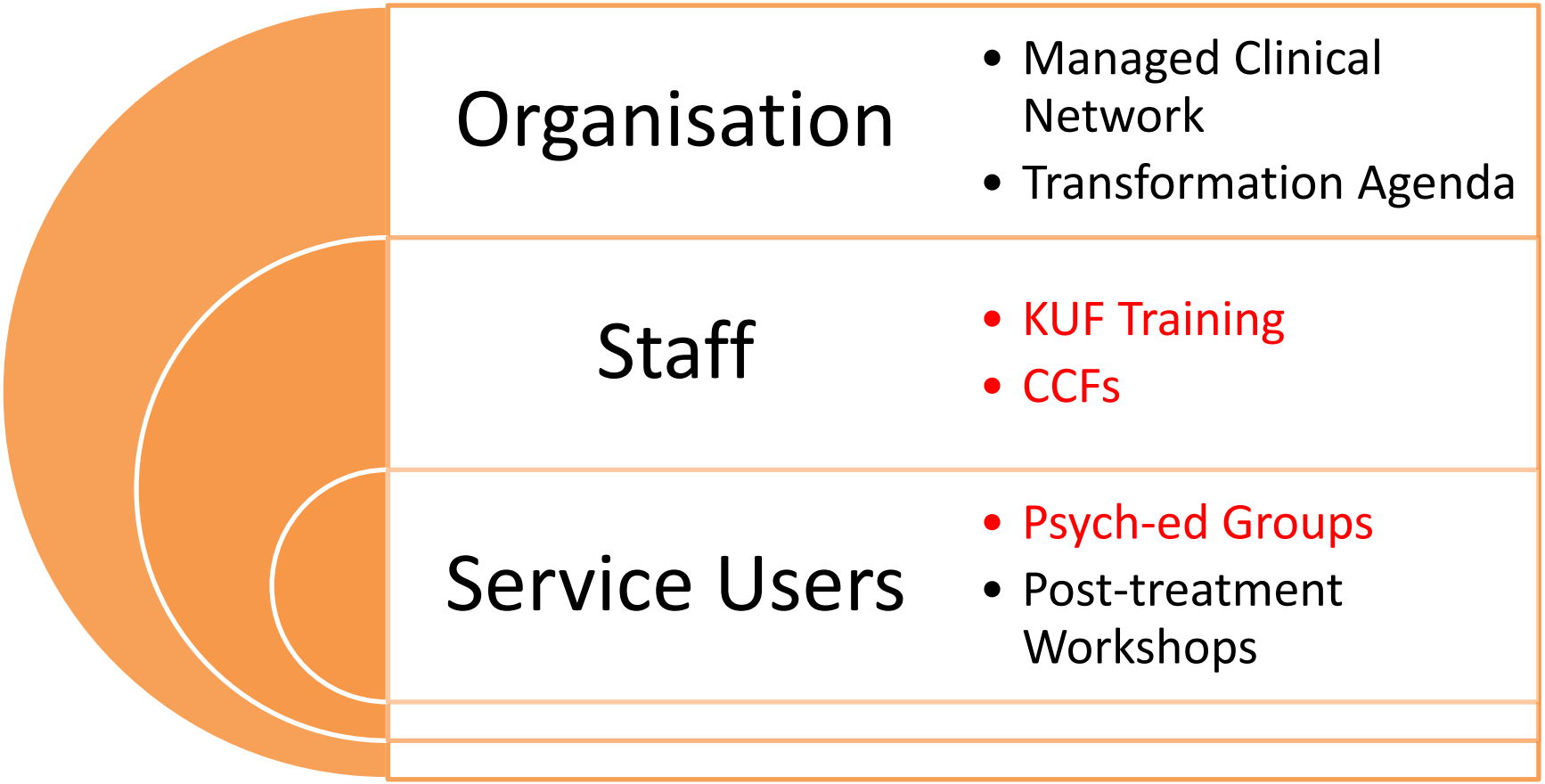


emergence
CHANGING ATTITUDES BUILDING LIVES

West London Mental Health NHS
NHS Trust

Personality Disorder
Managed Clinical Network

Whole Systems Approach



Knowledge & Understanding Framework

- Collaboration between IMH Nottingham, Tavi, OU and emergence
- came out of National PD programme
- 3 levels of training, basic one is 3 day with VLE component
- Over 40,000 have been trained in KUF
- All settings: health, Prisons, probation, housing etc…
- All backgrounds: Professionals, Service Users, Carers etc.
- Co designed and co delivered
- Experiential component is very important

KUF awareness level Evaluation

- 372 (82%) pre and 3 months post training questionnaires completed
- Understanding of diagnosis: rose from 41% to 84%
- Increased empathy: from 68% to 96%
- Increased confidence: rose from 69% to 91%
- Negative emotional responses: declined from 20% to 11%;
- Impact of training to improve working practices: 93%.
- Maslach Burnout Inventory @ 3 months post training
  - No Change “exhaustion”
  - Increased “personal accomplishment”
  - Decreased “depersonalisation

Parker, J (2016) ‘Knowledge and Understanding Framework: Evaluation for the Pan London Region – Report for Commissioners - 2015/16’

Training to change staff attitude

- Low secure PD service
- 90 minute training session
- Pre & 8 week post training questionnaires
  - ↑ in knowledge
  - ↑ locus of origin scale – (measure of aetiological beliefs)
  - But - No change in Empathy

C. Clark Et al. Can teaching staff about the neurobiological underpinings of borderline personality disorder instigate attitudinal change. Journal of Psychiatric Intensive Care Vol 11 No1:43-51

Lessons from KUF and LSU project

- Even a small amount of training can make a difference
- Attitudes can quite easily be changed
- Empathy is more difficult
- Service user collaboration can make a big difference
- Training is only a useful first step, even the KUF shows that the effects tail off over time.

Complex Case Forums

- Series of monthly or fortnightly forums;
- Co-facilitated
- Designed specifically for multi-disciplinary staff teams
- Develop understanding, skills, competencies and confidence
- Opportunity to embed training into day-to-day practice – address tail off

CCF - Qualitative feedback:

- *"I feel more competent"*
- *"I have a better understanding of why they have developed PD"*
- *"I can see the link between trauma and PD"*
- *"Aware the trauma they have been through has shaped their lives…. I am more sympathetic"*
- *"Having a service user perspective makes it more realistic"*
- *"SU perspective is integral to reflections"*

Working with patients

- Brief interventions have too often been overlooked
- Psychological education is increasingly used
- Much more flexible than “therapy”
- Difficult to reach can engage

Psychological Education in secure setting

- Female MSU, specialising in PD
- Six Sessions – “understanding PD”
- 61% completers
- Completers demonstrated
  - ↑ insight
  - ↓ BPRS
  - ↑ in wider engagement (e.g. primary nurse, activities)
  - ↓ staff rated self-harm

C Long Et al. Using Psychoeducation to motivate engagement for women with personality disorder in secure settings. Journal of Psychiatric Intensive Care Vol 11 No1:18-26

Psych-ed Groups

- Co-produced and co-facilitated;
- Ten week course
- Self-referral
- Incorporates group work and role plays;
- Uses skills taken from MBT, DBT, Art Therapy and Psychoanalytic Psychotherapy;
- LATER – 'Learning about Thinking, Emotions and Relationships'
- Roughly 80% retention over 10 weeks

Psych-ed Groups – Qualitative data

"It has been useful to hear other's life experiences and not to feel so alone."

"Thinking about my attachment style and those of others has already helped me to enjoy a particular relationship more and I fully expect it to help with other relationships."

"[The course has helped me] to be a better, more aware person and a better mum."

"[The most useful aspect of the course] was about relationships. Also the most painful parts because I realise now I never actually dealt with those feelings."

"MBT as a way of helping me to pause and understand my thoughts and feelings and what may be going on for the other person and not presuming I know."

"The information was offered in a non-patronising and supportive way. I felt like an adult learner not a 'patient'."

Co-Production – Our lessons

- Pay people properly
- Involve them right at the beginning
- Protect one another – employ those treated elsewhere
- Different people go at different speeds
- It takes time, but the investment is worth it
- Be open

Co-Production – what it brings

- Brings creativity and innovation
- Builds confident clinicians
  - Greater understanding of the lived experience
  - Knowing when to challenge
  - Supports positive risk taking
  - Informs formulation – opens up dialogue
- Inspires clinicians, service users and carers
- “humanises” one another

Priorities for our clinical settings

- Community Meeting
- Some form of reflective practice (CCF)
- Staff training
- Psyche Ed

Question?

- What learning can be taken to our clinical settings?
- Are there any priorities for your service

Particular challenges

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Factors that build resilience for the TEAM

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