North East Essex
Clinical Commissioning Group

**DEVELOPING PERSONALITY DISORDER SERVICES ACROSS NORTH ESSEX (2014-2017)**

**STATEMENT OF AMBITION**

**Background and Introduction**

A north Essex personality disorder (PD) strategy is being developed as part of the wider North Essex Joint Commissioning Strategy and will set out the vision and approach to mental health commissioning for PD services across north Essex up to 2017 and ensure that commissioning achieves the best possible quality care and outcomes and that services are accessible and aligned to physical health needs.

People with PD currently need to access a wide range of local services; they tend to have relatively frequent contact across a spectrum of these services including mental health and substance misuse.

In January 2003 the National Institute for Mental Health in England (NIMHE) published a Best Practice Guidance[1]. In addition to this they produced a capabilities framework in November 2003*, Breaking the Cycle of Rejection:* The Personality Disorder Capabilities Framework.

In January 2009 the National Institute for Health and Care Excellence[2] (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. The key areas for this pathway are;

- **Access to services -** People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed.
- **Autonomy and choice -** Work in partnership with people with borderline personality disorder to develop their autonomy and promote choice
- **Developing an optimistic and trusting relationship -** When working with people with borderline personality disorder explore treatment options that are built on trust and consistent.
- **Managing endings and supporting transitions –** Anticipate withdrawal and ending of treatments or services (including transition from one service provider to another)

It is these strategies that influence the north Essex strategy. Commissioning intentions and procedures will be transparent through the involvement of local people in shaping services.

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-severe PD whose needs can generally be met by local community services. These services are commissioned by local Clinical Commissioning Groups (CCG's) and may include services that include consultation, psychological support, community-based treatment, day services, and crisis support.

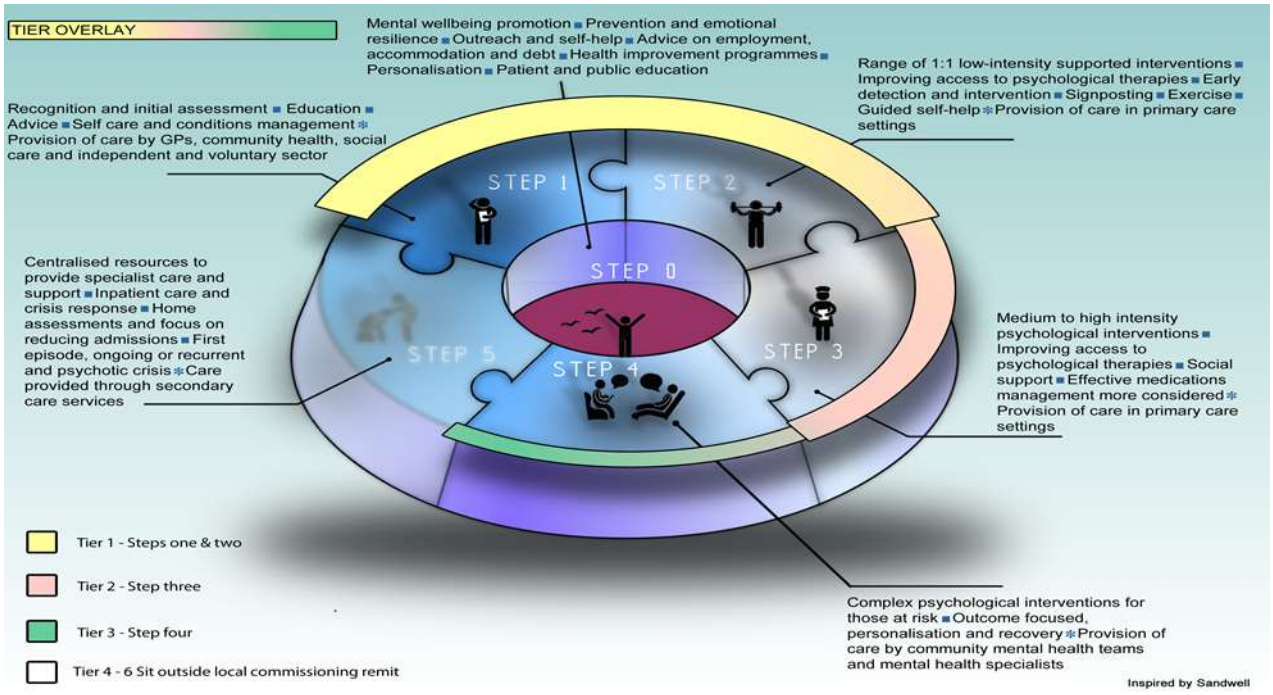
[1] Personality disorder: No longer a diagnosis of exclusion. *Policy implementation guidance for the development of services for people with personality disorder*

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

Tiers 4-6 are specialised services for people with severe and complex needs or those requiring longer-term residential rehabilitation or treatment at required levels of security. These tiers of services are commissioned regionally and nationally by NHS England and the Ministry of Justice.

For the purpose of the north Essex Personality Disorder Strategy the focus is on tier 1-3 services, it is our ambition to align these tiers to our North Essex Stepped Model of Care as below in Diagram One.

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




Personality disorders are common, present in one person in twenty of the population, and for those people severely affected cause significant distress to the sufferer, their family and friends. Such distress may be evidenced by self-harm, substance misuse, depression, eating disorders or other mental health difficulties, as well as childcare and social problems. Also, it is generally acknowledged that personality disorders are caused by a combination and interaction of genetic vulnerability and adverse early experiences, such as abuse and neglect. People with personality disorders are already heavy users of our health, social care and Criminal Justice services yet there is little evidence to show whether the traditional model of care provision addresses their needs and, in the absence of dedicated provision, they may not receive the optimal care.

Specialist secondary care mental health services are offered to people with a diagnosis of Personality Disorder within Tier 3. There is very limited good-quality evidence about what happens at the moment to people with PD. However, such evidence that does exist suggests that in addition to crisis management, hospital admission, community review and psychological therapy, people with personality disorder can struggle to engage with services. They frequently become revolving door patients, attempting to obtain help from a wide range of community services that are often unable to meet the perceived presenting needs. This is experienced as rejection even when the people with a diagnosis of PD themselves can at times turn down the care that is made available, for a number of reasons. There are particular problems in primary care when specialist services struggle to engage or draw a boundary in what is offered to people with a diagnosis of PD and the primary service is then people's GPs. Like other clinical staff, GPs and other disciplines within primary care teams have very little specific training in the diagnosis, treatment and management of PD; yet, they are frequently the first point of contact for many service users.

There is a need for planned evaluation of PD services against desired outcomes, both in terms of clinical outcomes and in terms of organisational functioning with clear accountability to the

organisations that are responsible for resourcing the achievement of these outcomes. As evaluation in this area is complex it should be standardised where possible across the various agencies that provide care and support, including the Criminal Justice Agencies (for transitions between Tiers 4 and 3) and linked to national recommendations and guidelines. It is therefore proposed that Personality Disorder Services should be subject to a variety of appropriate services, therapeutic and economic evaluations, to be designed in the planning stages of service development.

In 2012 six demonstration sites were established as part of national developments to deliver good quality psychological interventions for people experiencing severe mental illness. Three of the six demonstration sites were identified as service model pilots for psychological interventions for people with a diagnosis of PD (the other three sites were addressing interventions for psychosis and bipolar disorder). This work is underway and experiences and learning are to be shared with commissioners and will introduce aspects of good practice and reach out to CCG clinical leads and leads of local personality disorder services. Already as a result of this work there are clear competency frameworks for psychological interventions for people with a diagnosis of personality disorder, developed at a national level with reference to NICE guidelines and an Expert Reference Group[3]. This document includes competencies for general clinical care and case management as well as specific individual psychological therapies. The three pilot sites are located in Somerset, Barnet, Enfield and Haringey and North East London. Barnet, Enfield and Haringey Mental Health NHS Trust are offering advice for commissioners in the South East area, including Quality Audit documents for services and commissioners.

To this end, a Personality Disorder Strategy outlining the aspirations of mental health services will be prepared with key stakeholders and discussed at the north Essex Advisory Group. This strategy will be built upon clinical service reviews and mapping of existing services within the main provider, North Essex Partnership University Foundation Trust (NEP) Primary Care and the voluntary sector. Discussions and debates with stakeholders will also be influential, with the statement being widely distributed to encourage and facilitate a period of engagement and feedback. The strategy will identify best practice against current provision and will influence objectives, outcomes, and plans for service development, along with recommendations for CCG boards. Consultation will be over the Summer of 2014 with plans for service development being open to discussion.

**Table 1:** The table below is designed to give an overview of our ambition for how our PD service will look across North Essex.

| **NORTH ESSEX AMBITION** |
|---|
| **To have a Personality Disorder Service;**<br>• in which patients are known and understood<br>• which aims to help patients to grow as individuals and recover as far as possible<br>• which is based on NICE guidelines and evidenced best practice<br>• in which clinicians have a high level of expertise and experience<br>• which operates within a therapeutic context according to individual formulations<br>• in which clinicians collaborate fully and creatively<br>• which will be cohesive and consistent from the point of view of the patient<br>• in which clinicians and patients are empowered to work together to take positive risks<br>• which will promote autonomy and avoid creating unhelpful dependencies of all sorts<br>• which will minimise organisational barriers and obstacles to access and clinical efficiency<br>• which will try to maintain patients in the community and minimise hospital admissions<br>• which will pay attention to difficulties experienced by patients at points of transition<br>• that supports integration of provider services; statutory and voluntary |

[3] A competence framework for psychological interventions with people with personality disorder: Anthony D. Roth and Stephen Pilling. Research Department of Clinical, Educational and Health Psychology, UCL

## Governance

The development of the North Essex Personality Disorder Strategy is overseen by the "North Essex Mental Health Advisory Group." It is being developed by a multi-agency working group which includes representatives from the three CCGs, Essex County Council, North Essex Commissioning Support Unit, Public Health, and representatives from children's services. Work streams include service user engagement, provider engagement, an editorial group and updating the needs assessment.

- The three CCGs remain the statutory bodies, who are accountable throughout the production of the strategy and they will be individually responsible for agreeing and signing off the final document.

## Demography and local context

The north Essex area is covered by three clinical commissioning groups (containing some 133 GP practices between them). The total population (all ages) for north Essex has risen from 974,191 in 2011 and is currently at 1,009,100[4]. Mid Essex has the largest population of 386,800, followed by north east Essex who have a population of 325,800 and west Essex who have a population of 296,500 patients.

It is predicted that there will be a 3.75% increase across north Essex for adults aged 18-64 with a mental health disorder (see table 2) rising from the current figure (2014) of 100,965 to 104,748 by 2020.

**Table 2:** Adults predicted to have Common Mental Disorders (CMD) and PD between 2014-2020 (aged 18-64) ***These figures do not give a full demonstration to the numbers of individuals who have a PD as it is not inclusive of mental health conditions where PD can present as a secondary diagnosis. This will be addressed fully in the PD strategy.***

| | Mid Essex | | NE Essex | | West Essex | |
|---|---|---|---|---|---|---|
| **Mental Health Disorder** | **2014** | **2020** | **2012** | **2020** | **2014** | **2020** |
| People predicted to have a common mental disorder | 37,120 | 37,664 | 30,464 | 32,207 | 28,625 | 29,934 |
| People aged 18-64 predicted to have a borderline personality disorder | 1,037 | 1,053 | 853 | 901 | 801 | 839 |
| People aged 18-64 predicted to have an antisocial personality disorder | 798 | 817 | 655 | 694 | 612 | 639 |

## Financial context

The strategy will set out the challenges faced within the current economic climate and the need to transform services – This is needed to control overall spend and meet the growth in demand whilst striving to deliver quality outcomes.

## Stakeholder engagement

**For further information, to provide feedback or to become involved in the engagement process please contact: ECSU.JointStrategies@nhs.net**

***"Our fundamental purpose will be to ensure that people with a personality disorder and mental ill health are appropriately supported and treated and that they maintain or regain their place in the local community, and achieve their full potential as members of that community."***

[4] http://www.pansi.org.uk/index.php (May 2014)