Healthcare Improvement Scotland

Clinical Network Learning Event Presentations of Concern: Personality Disorder with Concurrent Substance Use

Mental Health and Substance Use
Thursday 2 November 2023

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

Welcome and introductions

Introduce yourself in the chat box!

Let us know your name and role

Benjamin McElwee
Senior Improvement Advisor and Delivery Lead for Mental Health and Substance Use; Healthcare Improvement Scotland

MS Teams Settings

This session will be recorded

The link will be shared, so those who are unable to join us today can listen to the session.

During the Q&A you will have the opportunity to turn your mic and camera on, please note the recording will be stopped and will NOT capture the camera or audio of attendees who speak during this

Agenda and aims of the day

Time	Item	Lead
10:00-10:05	Welcome and Aims	**Benjamin McElwee** Senior Improvement Advisor and Delivery Lead for Mental Health and Substance Use, Healthcare Improvement Scotland
10:05-10:45	Presentation	**Dr Timothy Agnew** Consultant Psychiatrist and Psychotherapist, NHS Highland Personality Disorder Service
10:45-11:00	Q&A and Open Discussion ○ Questions for Tim ○ Audience clinical experiences ○ Other common complex presentations	**All**
11:00-11:15	Personality Disorder Improvement Programme overview and overlaps	**Gordon Hay** Senior Improvement Advisor, Healthcare Improvement Scotland
11:15-11:20	Next Steps and Close	**Benjamin McElwee**

Individuals with multiple needs may face particular challenges requiring support.

This session will explore tools to better understand and support individuals with complex presentations including personality disorder and substance use.

Healthcare Improvement Scotland

Personality Disorder and Substance Use

Dr Timothy Agnew

Consultant Psychiatrist and Psychotherapist, NHS Highland
Personality Disorder Service

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Overview

- What is meant by the term “personality disorder”?
- How is personality disorder thought to develop?
- How do mental health services respond to personality disorder?
- Personality disorder and substance use
- Discussion

WHAT IS MEANT BY THE TERM “PERSONALITY DISORDER”?

ICD-11 Personality Disorder

- Summary of changes ICD-10 vs ICD-11
- Process of diagnosis
- General criteria for Personality Disorder
- Severity dimension
- Trait domain specifiers
- Borderline Pattern
- Personality Difficulty
- Complex Post-Traumatic Stress Disorder

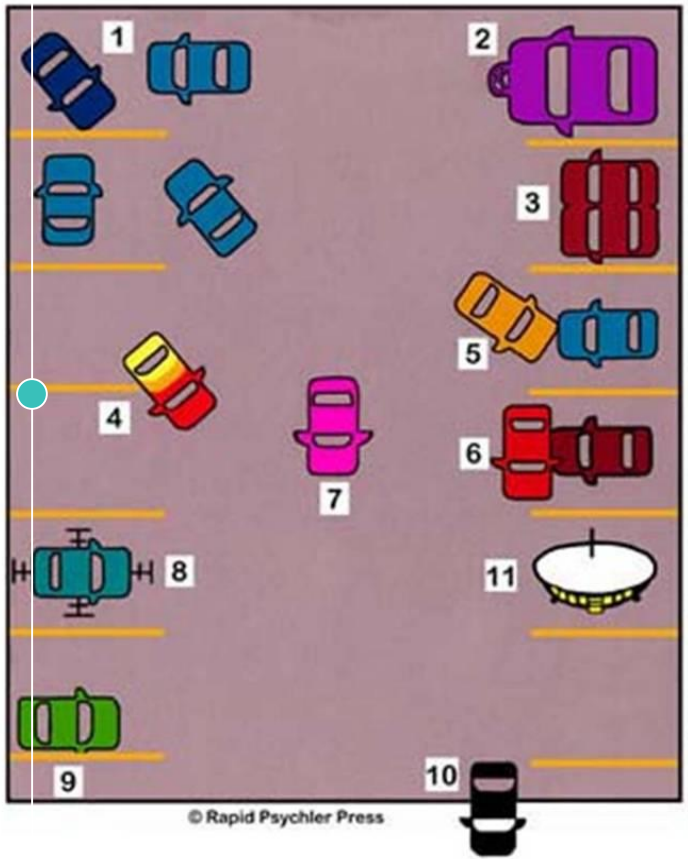
Summary of main changes between ICD-10 and ICD-11

- Severity dimension
- Trait domain specifiers
- Borderline pattern
- Age criterion
- Persistence criterion
- Stability criterion
- Personality difficulty (as factor influencing health)
- CPTSD

Personality

- Personality refers to an individual's characteristic way of behaving, experiencing life, and of perceiving and interpreting themselves, other people, events, and situations

Parking Lot of the Personality Disordered



1. PARANOID - Cornered again!!
2. NARCISSIST - Largest car; prominent hood ornament
3. DEPENDENT - Needs other cars to feel sheltered
4. PASSIVE-AGGRESSIVE - Angles car to take 2 spaces
5. BORDERLINE - Rams into car of ex-lover
6. ANTISOCIAL - Blocks other cars
7. HISTRIONIC - Parks in center of lot for dramatic effect
8. OBSESSIVE - Perfect alignment in parking space
9. AVOIDANT - Hides in corner
10. SCHIZOID - Can't tolerate closeness to other cars
11. SCHIZOTYPAL - Intergalactic parking

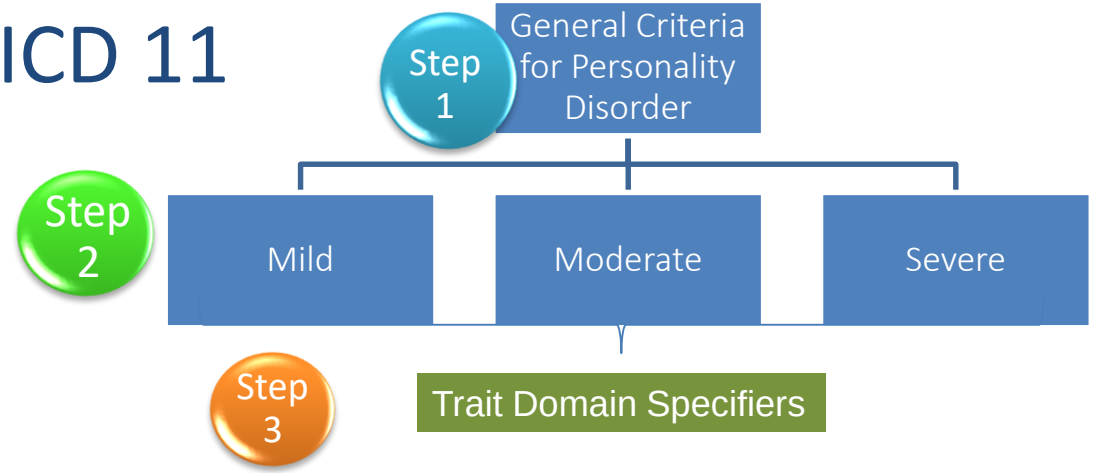
Personality Disorder

- Personality Disorder is a marked disturbance in personality functioning, which is nearly always associated with considerable personal and social disruption
- The central manifestations of Personality Disorder are impairments in functioning of:
  - aspects of the self
  - problems in interpersonal functioning
- Impairments in self-functioning and/or interpersonal functioning are manifested in maladaptive patterns of:
  - cognition,
  - emotional experience and emotional expression
  - behaviour

Diagnosing Personality Disorder

- Diagnosing ICD-11 personality disorder is a 3 stage process:
  - Essential features (general criteria)
  - Severity (mild, moderate, severe)
  - Trait Domains
    - Negative affectivity
    - Detachment
    - Disinhibition
    - Disociality
    - Anankastia
    - (Borderline Pattern)

ICD 11



Negative Affectivity

Tendency to experience a broad range of negative emotions

Detachment

Tendency to maintain social distance and emotional distance

Dissociality

Tendency to disregard the rights and feelings of others, encompassing self-centredness and lack of empathy

Disinhibition

Tendency to act rashly based on immediate external or internal stimuli

Anankastia

Tendency for a narrow focus on one's rigid standards of perfection and right and wrong and on controlling oneself, others and situations to ensure these standards are met

Borderline pattern

6D10 General Diagnostic Requirements for Personality Disorder – Essential Features

- An enduring disturbance characterized by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships)
- The disturbance has persisted over an extended period of time (e.g., lasting 2 years or more)
- The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated)
- The disturbance is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles), though it may be consistently evoked by particular types of circumstances and not others

6D10 General Diagnostic Requirements for Personality Disorder – Essential Features

- The symptoms are not due to the direct effects of a medication or substance, including withdrawal effects, and are not better accounted for by another mental disorder, a Disease of the Nervous System, or another medical condition)
- The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning
- Personality Disorder should not be diagnosed if the patterns of behaviour characterizing the personality disturbance are developmentally appropriate (e.g., problems related to establishing an independent self-identity during adolescence) or can be explained primarily by social or cultural factors, including socio-political conflict.

General criteria summary

- Enduring disturbance of self and interpersonal functioning
- Persisting for 2 years or more
- Problematic patterns of maladaptive:
  - Cognition
  - Emotional experience and expression
  - Behaviour
- Pervasive across a range of situations
- Not due to substances, physical or mental disorder
- Associated with distress and/or dysfunction
- Not developmentally appropriate
- Not explained primarily by socio-cultural factors

Disturbances in functioning of aspects of the self

- Stability and coherence of one's sense of **identity** (eg, extent to which identity or sense of self is variable and inconsistent or overly rigid and fixed)
- Ability to maintain an overall positive and stable sense of **self-worth**
- Accuracy of one’s view of one’s characteristics, strengths, limitations **(self-appraisal)**
- Capacity for **self-direction** (ability to plan, choose, and implement appropriate goals)

Interpersonal dysfunction across various contexts and relationships

- Interest in engaging in relationships with others
- Ability to understand and appreciate others' perspectives
- Ability to develop and maintain close and mutually satisfying relationships
- Ability to manage conflict in relationships

Pervasiveness, severity, and chronicity of specific manifestations of the personality dysfunction

- Emotional manifestations
- Cognitive manifestations
- Behavioural manifestations

Emotional manifestations

- Range and appropriateness of emotional experience and expression
- Tendency to be emotionally over-reactive or under-reactive
- Ability to recognize and acknowledge emotions that are difficult or unwanted by the individual (eg, anger, sadness).

Cognitive manifestations

- Accuracy of situational and interpersonal appraisals, especially under stress
- Ability to make appropriate decisions in situations of uncertainty
- Appropriate stability and flexibility of belief systems

Behavioural manifestations

- Flexibility in controlling impulses and modulating behaviour based on the situation and consideration of the consequences
- Appropriateness of behavioural responses to intense emotions and stressful circumstances (eg, propensity to self-harm or violence)
- Risk of harm to self or others is typically related to the behavioural manifestations of personality dysfunction

Distress and dysfunction

- The extent to which the dysfunctions in the above areas are associated with **distress** or **impairment** in:
  - personal family
  - social
  - educational
  - occupational
  - or other important areas of functioning

Severity dimension summary

Problem Area	MILD Personality Disorder	MODERATE Personality Disorder	SEVERE Personality Disorder
Disturbance in functioning of self	Less pervasive, mild	More pervasive, moderate	Broadly pervasive, severe
Disturbance in interpersonal relationships	Many relationships, mild problems	Most relationships, moderate problems	Virtually all relationships, severe problems
Specific manifestations of personality disorder	Mild	Moderate	Severe
Harm to self or others	Rarely	Sometimes	Often
Disturbance in personal, social and occupational functioning	Moderate impairment in some areas or mild impairment in more areas	Moderate impairment in most areas	Severe impairment in virtually all areas

Trait domain specifiers

- **Negative Affectivity** (B5 high Neuroticism)
- **Detachment** (B5 low Extraversion)
- **Dissociality** (B5 low Agreeableness)
- **Disinhibition** (B5 low Conscientiousness)
- **Anankastia** (B5 high Conscientiousness)
- (**Borderline Pattern**)
- These traits will often be present in individuals without personality disorder but the pervasiveness, persistence, degree of expression and associated problems will increase with more severe personality disturbance

Negative Affectivity

- **The core feature of the Negative Affectivity trait domain (sometimes referred to as Neuroticism) is the tendency to experience a broad range of negative emotions**
- Common manifestations include:
  - Experiencing a broad range of negative emotions with a frequency and intensity out of proportion to the situation
  - Emotional lability and poor emotional regulation
  - Negativistic attitudes
  - Low self-esteem and self-confidence
  - Mistrustfulness

Detachment

- **The core feature of the Detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment)**
- Common manifestations include:
  - Social detachment
  - Emotional detachment

Dissociality

- **The core feature of the Dissociality trait domain is disregard for the rights and feelings of others, encompassing both self-centeredness and lack of empathy**
- Common manifestations include:
  - Self-centredness
  - Lack of empathy

Disinhibition

- **The core feature of the Disinhibition trait domain is the tendency to act rashly based on immediate external or internal stimuli (sensations, emotions, thoughts), without consideration of potential negative consequences**
- Common manifestations include:
  - Impulsivity
  - Distractibility
  - Irresponsibility
  - Lack of planning

Anankastia

- **The core feature of the Anankastia trait domain is a narrow focus on one's rigid standard of perfection and of right and wrong, and on controlling one's own and others' behaviour and controlling situations to ensure conformity to these standards**
- Common manifestations include:
  - Perfectionism
  - Emotional and behavioural constraint

Borderline Pattern

- The ICD-11 Borderline Pattern can be taken as equivalent to DSM-4 Borderline Personality Disorder
- Borderline Pattern is **not** a trait domain specifier
- There is considerable overlap between this pattern and information contained in the trait domain specifiers (most typically Negative Affectivity, Dissociality and Disinhibition)
- As well as trait-based features, Borderline Pattern description also contains psychiatric symptoms (eg dissociation) and features relating to specific behaviours (eg parasuicidal behaviour)
- However, it has been included to enhance the clinical utility of ICD-11 and can help identify individuals who may respond to specific treatments

Borderline Pattern is an additional specifier

- Borderline Pattern should be considered as an additional specifier only once the other relevant trait domain specifiers have been applied
- Borderline Pattern significantly overlaps with Disinhibition, Negative Affectivity, Dissociality
- Many clinical presentations which in previous diagnostic systems may have attracted a diagnosis of BPD or EUPD may be more appropriately described by the Negative Affectivity specifier

Complex Post-Traumatic Stress Disorder (CPTSD)

- One of the new diagnostic categories in ICD-11 is Complex Post-Traumatic Stress Disorder
- Prior to ICD-11 CPTSD was used as a diagnostic category by some clinicians but there was variation in what was meant by the term
- ICD-11 CPTSD bears marked similarities to the problems associated with Personality Disorder, together with PTSD symptoms
- At least 50% of people with a diagnosis of Borderline Prsonality Disorder also meet criteria for PTSD
- At least 75% of people with a diagnosis of Borderline Personality Disorder have been exposed to a major traumatic event

Post-Traumatic Stress Disorder

- Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature
- Following the traumatic event or situation, the development of a characteristic syndrome lasting for at least several weeks, consisting of all three core elements:
  - Re-experiencing the traumatic event in the present, in which the event(s) is not just remembered but is experienced as occurring again in the here and now. This typically occurs in the form of vivid intrusive memories or images
  - Deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s)
  - Persistent perceptions of heightened current threat

Complex Post-Traumatic Stress Disorder

- All features of PTSD must be present
  - Exposure to significant traumatic event(s)
  - Intrusive re-experiencing
  - Avoidance
  - Heightened perception of current threat
- Plus a triad of areas of dyregulation:
  - Emotion dyregulation
  - Self-concept dysregulation
  - Interpersonal dysregulation
- Associated with significant impairment of functioning

CPTSD and Personality Disorder

- The features of the triad of dysregulation in CPTSD overlaps significantly with the features of personality disorder, in particular the borderline pattern
- If PTSD features co-occur in someone with a diagnosis of Personality Disorder, a diagnosis of CPTSD should be made rather than PTSD as problems in emotion regulation, self-concept regulation and relationship regulation will be present
- ICD-11 recognises this and states: “The utility of assigning an additional diagnosis of Personality Disorder in such cases [where a diagnosis of CPTSD has been made] depends on the specific clinical situation”
- The features of CPTSD need only be present for “several weeks” whereas the features of Personality Disorder must be present for “at least 2 years”

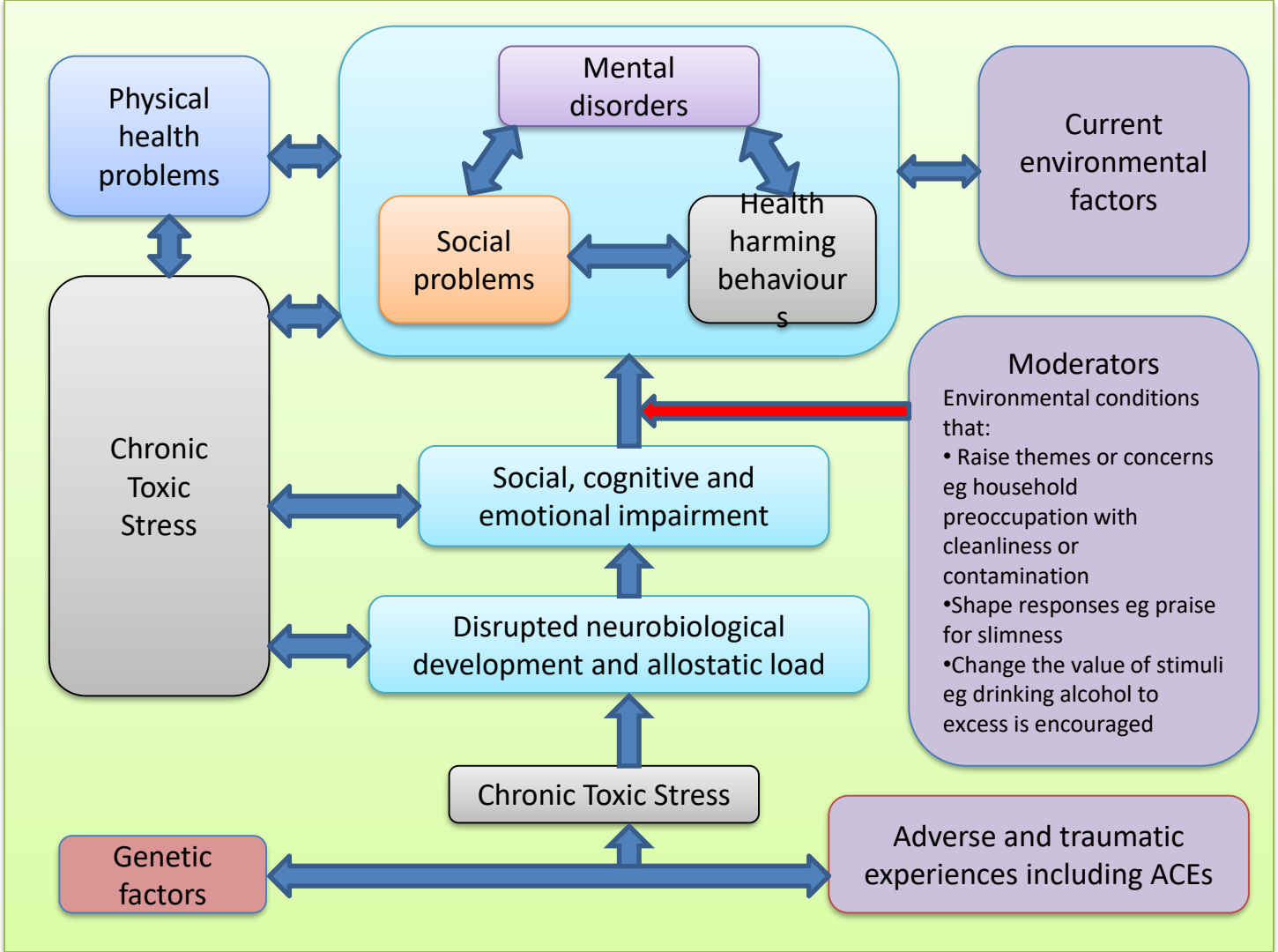
Complex PTSD summary

- PTSD…
  - Re-experiencing
  - Avoidance
  - Hyperarousal
- …plus
  - Self-concept disturbance
  - Emotion regulation disturbance
  - Relationship disturbance
- **Questionable whether PTSD can be diagnosed (rather than CPTSD) if criteria for personality disorder are met**
- **Clarifies previously muddy terminology**

HOW IS PERSONALITY DISORDER THOUGHT TO DEVELOP?

Contributing factors

- Heritable factors (about 40%)
  - Temperamental factors
- Environmental factors (about 60%)
  - Adverse experiences
- Transactional processes between these factors


Physical health problems
Mental disorders
Social problems
Health harming behaviours
Current environmental factors
Chronic Toxic Stress
Social, cognitive and emotional impairment
Disrupted neurobiological development and allostatic load
Moderators
Environmental conditions that:
• Raise themes or concerns eg household preoccupation with cleanliness or contamination
•Shape responses eg praise for slimness
•Change the value of stimuli eg drinking alcohol to excess is encouraged
Chronic Toxic Stress
Genetic factors
Adverse and traumatic experiences including ACEs

Management

- General principles
- Overall structure and sequencing of care and treatment
- Specific interventions

General Principles

- Collaboration
- Consistency
- Validation
- Motivation
- Self-management

Structure and sequencing

- Phase-based approach
- Dr John Livesley (but also Dr Judith Herman, Dr Pierre Janet etc.)

Phase-based approach

- Phase 1 (PRESENT) Safety and stabilisation
    - Safety and containment
    - Regulation and control
- Phase 2 (PAST) Exploration and change
    - Includes trauma reprocessing
- Phase 3 (FUTURE) Integration and synthesis
    - Reconnection

Locally available interventions with a Phase 1 focus

- The Decider
- Supporting Self Management Service
- STEPPS
- Dialectical Behaviour Therapy

- Plus other non-PD specific interventions which may address co-occurring issues and conditions

Locally available interventions with a Phase 2 focus

- Trauma focused CBT
- EMDR

- Plus other non-PD specific interventions which promote reflection/change on long-standing patterns of thinking and behaving

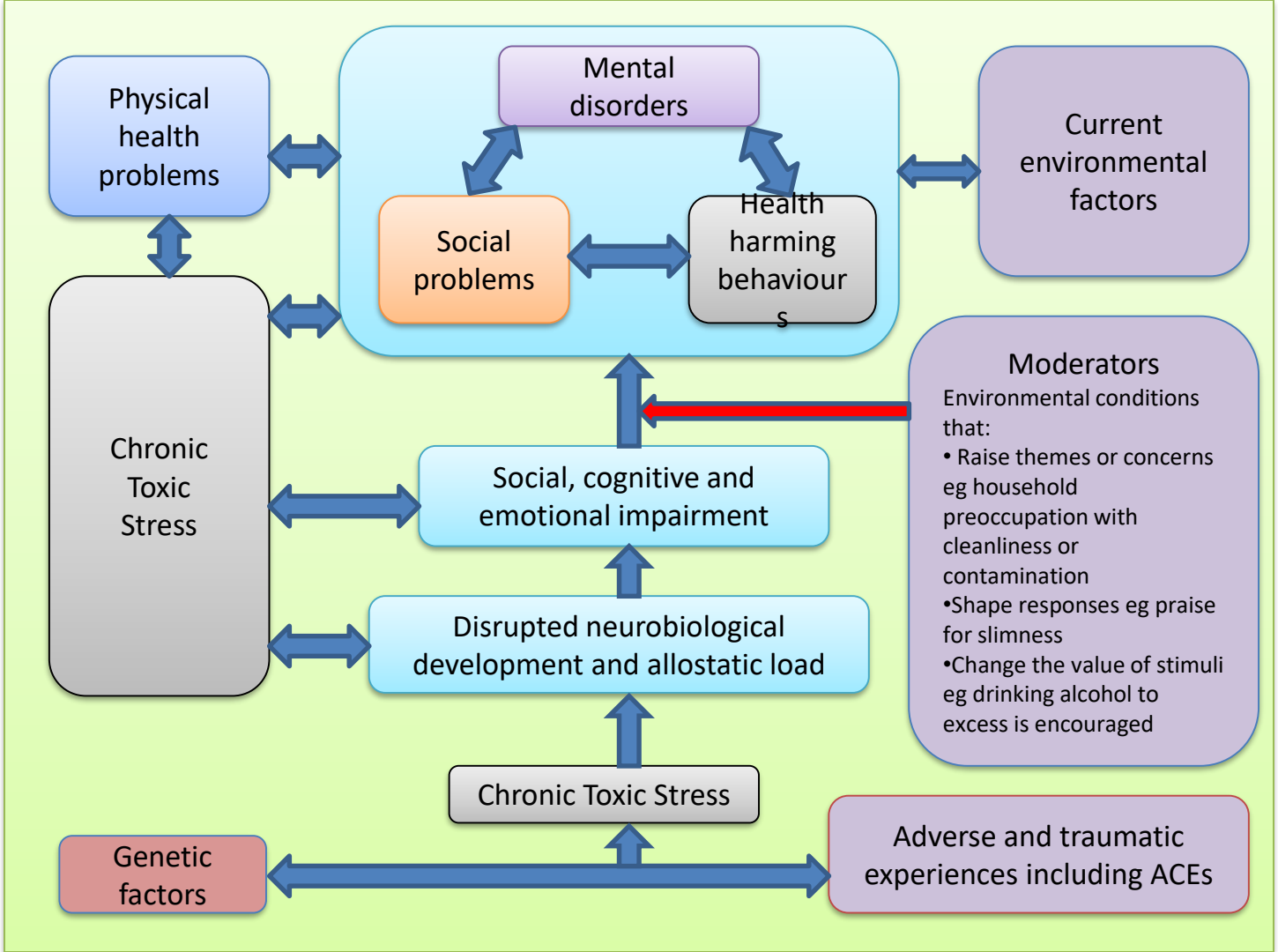
Locally available interventions with a Phase 3 focus

- CAS Day Service
- Vocational Support

- Plus other non-PD specific interventions which promote developing new roles, relationships and responsibilities

Role of skills training in stabilisation

- The Decider, STEPPS and DBT are primarily self-management (including emotion regulation) skills training interventions
- See diagram for rationale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Genetic factors
Adverse and traumatic experiences including ACEs

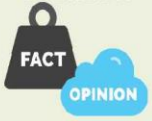
THE DECIDER

? ACCEPT

DISTRESS TOLERANCE

	IT WILL PASS 
DISTRACT 	DO ONE THING  20 MINUTES
TURN THE MIND 	RIGHT NOW 
SOOTHE 	VALUES 

MINDFULNESS

BREATHE 	OBSERVE 
THIS MOMENT 	FOCUS 
DRIFT 	FACT OR OPINION 
WISE MIND 	

CHANGE ?

EMOTION REGULATION

SELF CARE 	THINK 
NAME THE EMOTION 	OPPOSITE ACTION 
SIEVE OR SPONGE? 	BUILD POSITIVE EXPERIENCES 
BALANCE 	PACE & PLAN 

INTERPERSONAL EFFECTIVENESS

LISTEN 	RESPECT 
REFLECT 	CRYSTAL CLEAR 
ASK or SAY NO 	MAINTAIN RELATIONSHIP 
TALK THE TALK 	END OR MEND 

PRACTICE PRACTICE PRACTICE

Resilience building

- The brain is plastic and the body wants to heal
- Practices that build resilience can modify toxic stress into tolerable stress, the brain can slowly undo many of the stress induced changes, and the body can start to recover
- Furthermore, if parents make these changes, it can help reduce intergenerational transmission of ACEs

Resilience

- Modern concepts of resilience originated in studying groups of young children who had been exposed to ACEs
- Some developed social, physical and mental health problems and some did not
- The set of characteristics found in the set of young people who were less negatively affected by adversity was termed “resilience”

Some factors related to resilience

- Emotion regulation skills
- Problem solving skills
- Sense of self-agency
- Hopefulness
- Effective interpersonal relationships

Personality disorder and substance use

- Due to significant under-diagnosis of personality disorder, reliable data is limited
- High rates of personality disorder apparent using structured interviews in various settings
- High rates of substance use in patients with personality disorder
- High rates of adverse effects and apparently greater risk of dependence

Personality disorder and substance use

- Substance use and personality disorder can exist in a vicious symbiosis
- What do you think might be the relationship between substance use and the following traits?
  - Negative Affectivity
  - Disinhibition
  - Dissociality
  - Detachment
  - Anankastia

Personality disorder and substance use

- Active physiological dependence is likely to prevent Phase 1 and 2 work for many and should usually be addressed before meaningful stabilisation or trauma work can take place
- Non-dependent (often very risky) use of various substances is very common (almost the rule) and can be targeted in personality disorder treatment if appropriate, often as a key factor in unhelpful behavioural sequences
- Some substances (including many psychotropics) can block emotional experiencing and emotional learning and may need to be addressed even if used in a non-dependent pattern

Open Discussion and Q&A

Personality Disorder Improvement Programme (PDIP)

Gordon Hay

Senior Improvement Advisor,
Healthcare Improvement Scotland

Introduction

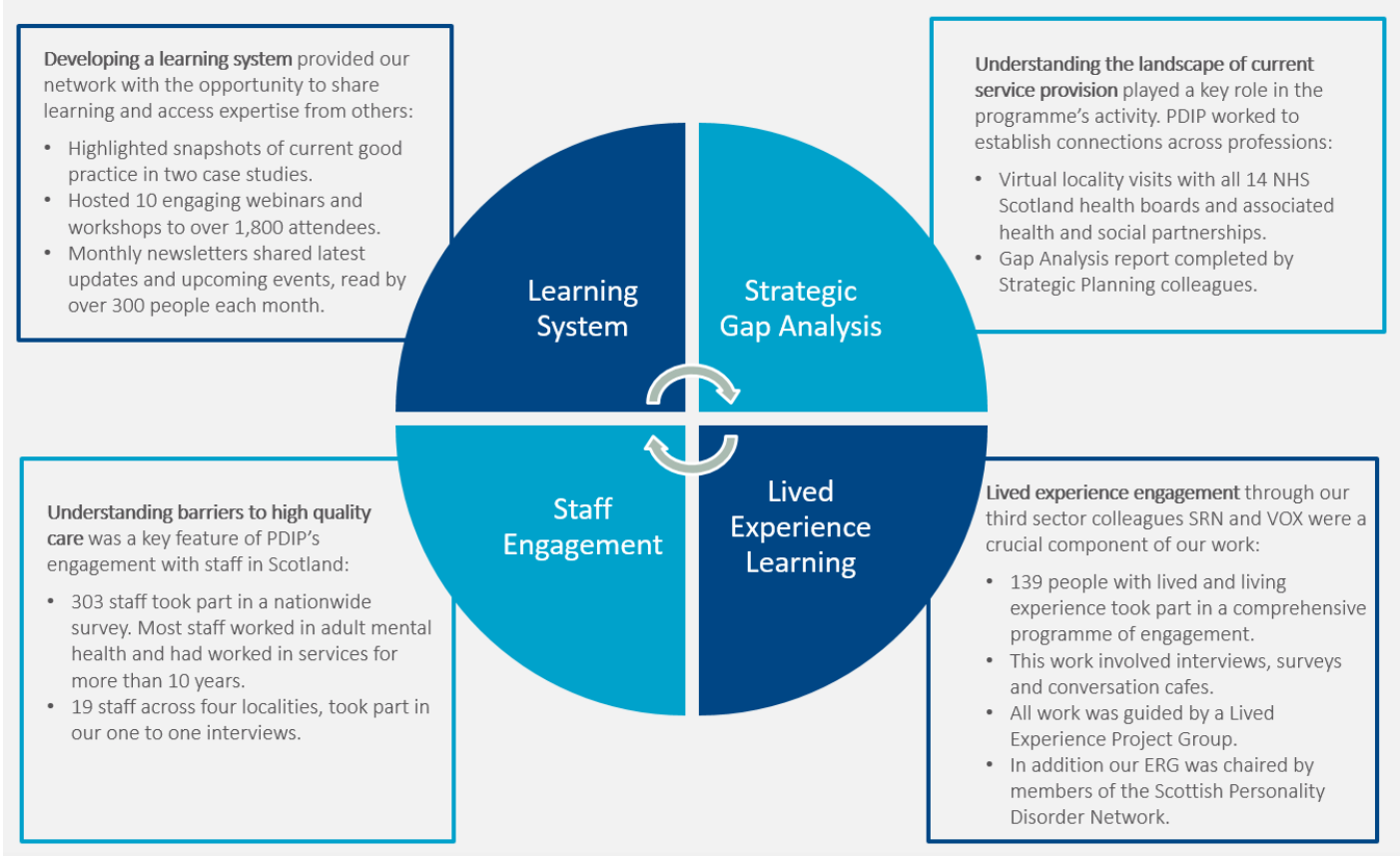
Phase 1 Remit

The Scottish Government commissioned Healthcare Improvement Scotland to deliver phase one of PDIP. The aim of this work was to understand the current state of provision and access to services for those with a diagnosis of personality disorder and identify areas for improvement in phase 2 of this work.

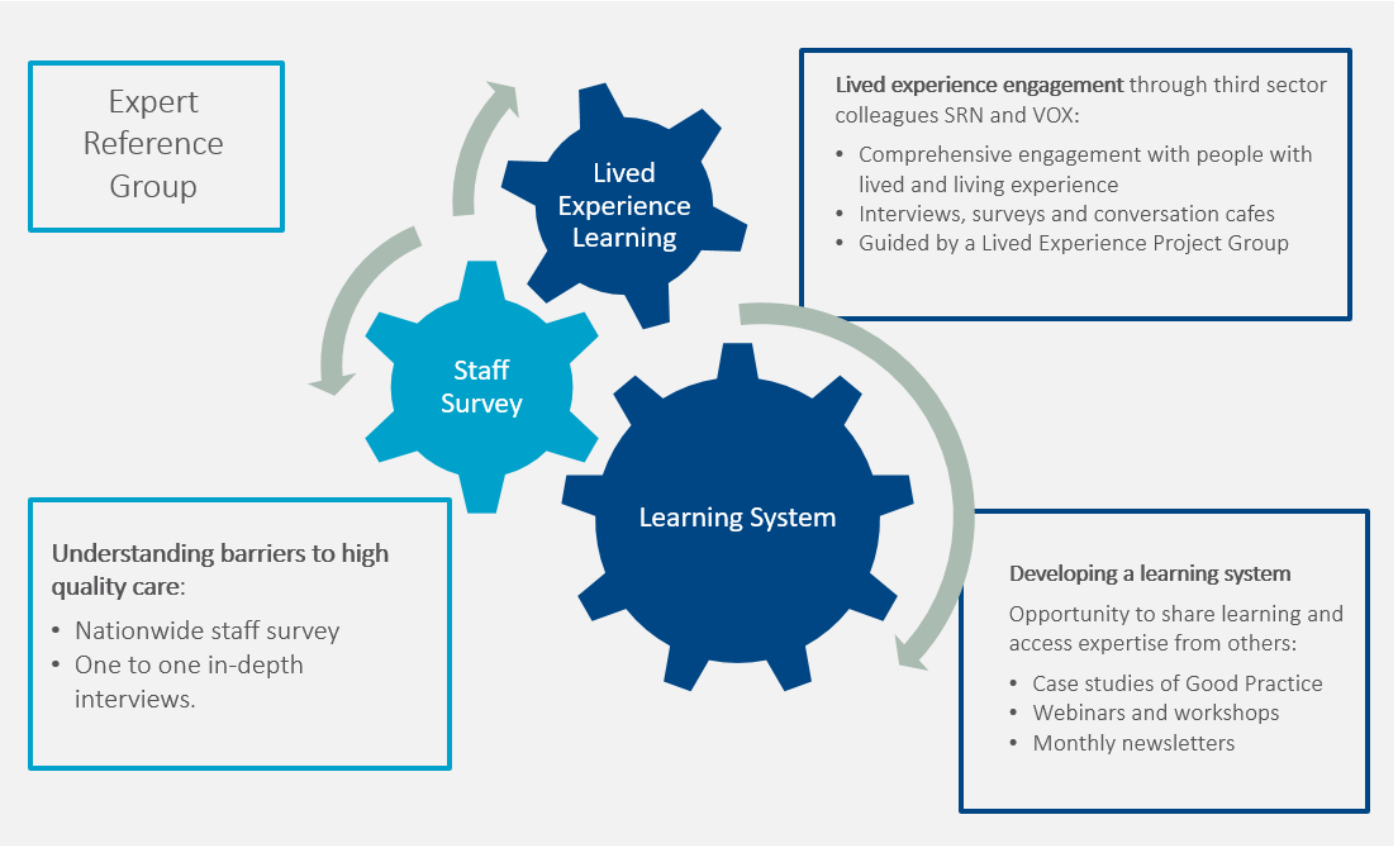
Note on language

The term personality disorder has been a source of discussion and debate nationally and internationally. Some people with lived experience and some professionals prefer to use other terminology to describe this range of symptoms. Within the PDIP programme of work, we recognise that this debate can be contentious and polarising. The aim is to respect these differences, whilst carrying out the work of reporting our findings on current services in Scotland and areas for improvement.

Core Components of PDIP 1



PDIP 1 Engagement Work



Learning from Lived Experience

Our third sector colleagues Scottish Recovery Network (SRN) and Voices of Experience (VOX) completed a comprehensive programme of engagement work with people identifying as having lived or living experience.

The five boxes below highlight the key themes identified in this piece of work:

- Language, stigma, discrimination and diagnosis
- Role of trauma and trauma responsive services
- Components of good service
- Taking a whole person, whole systems approach
- Developing peer support

Staff Engagement

Survey and interview outcomes

303 staff took part in an online survey

Nurses	48%
Psychology	25%
OT	8%
Psychiatry	6%
Other	13%

91% felt that they had the knowledge

82% felt they had the skills

93% felt they had the empathy to work well with people

76% reported limitations to their service

96% reported challenges to working in this area

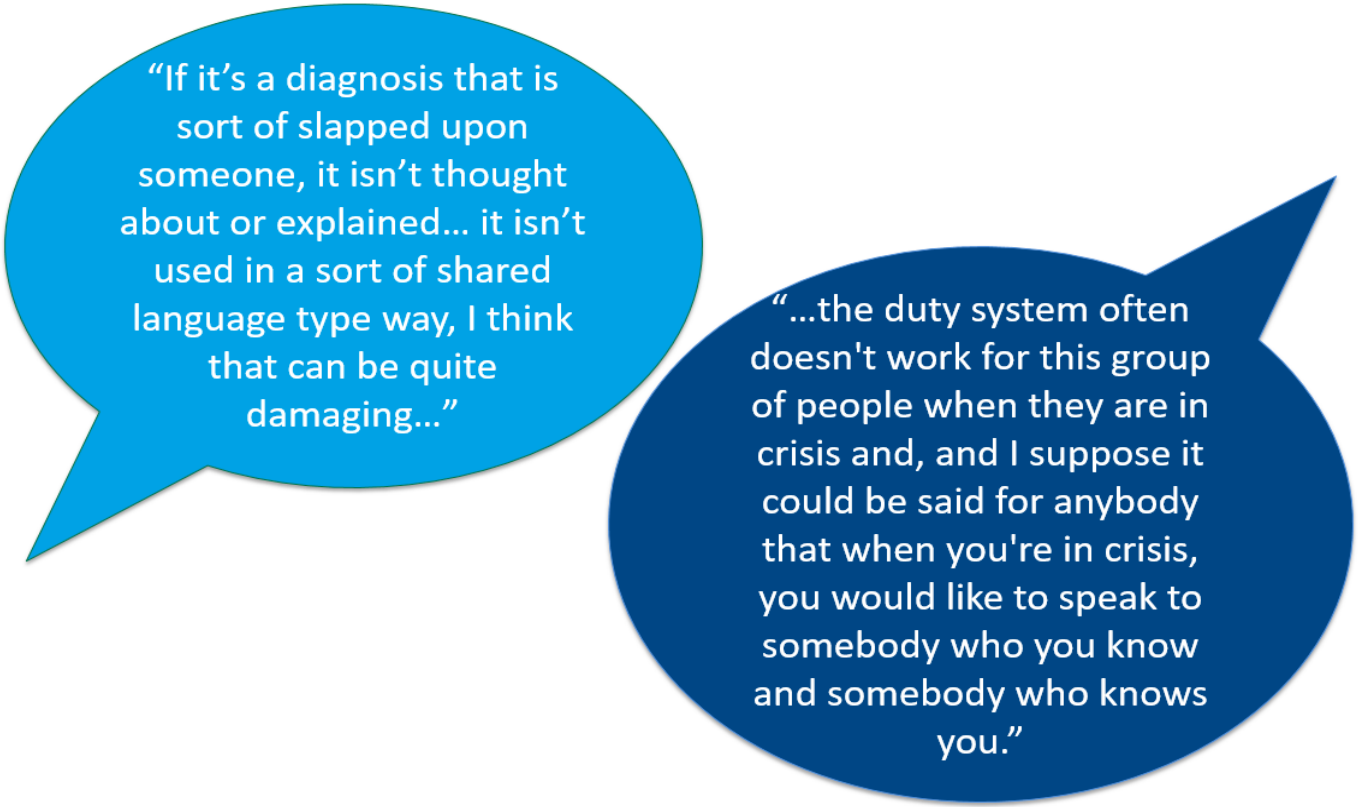
Rewards

- Seeing services and access to services improve
- Building relationships and enjoying working with those with a diagnosis
- Being part of a team with one vision
- Having the ability to be flexible in service/approaches used
- Reductions in stigma in staff and services
- Seeing people move on in their recovery
- Growing skills and confidence as a practitioner

Challenges

- Stigmatising attitudes around diagnosis and language
- Issues with service design (lack of communication, arbitrary targets and practices of disengage-discharge)
- Limited access to services nationwide
- Variable access to staff training
- Service wide pressures on staff and impacts on staff wellbeing
- Managing relationships with clients and teams
- Inconsistency and lack of one team vision

Staff Survey Quotes (Based on 19 in depth interviews with a range of staff)



PDIP 1 Learning System

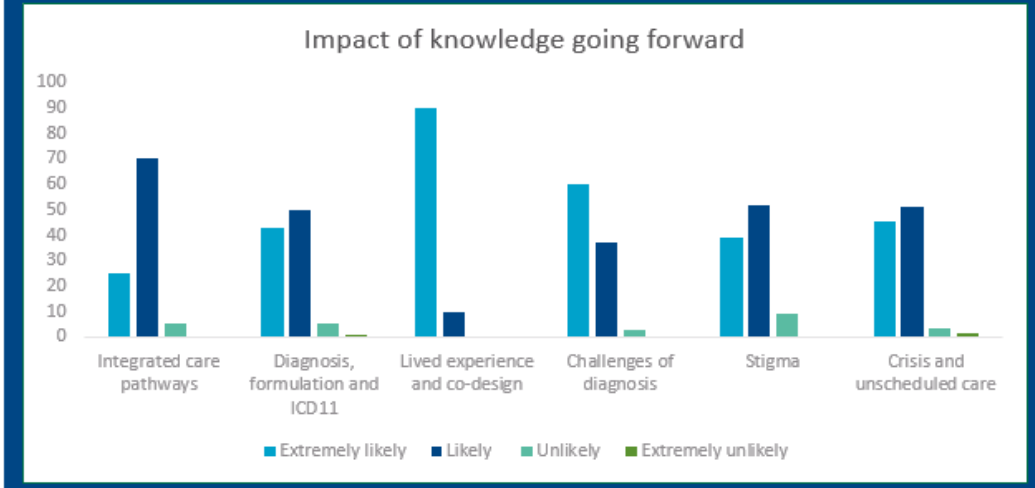
The PDIP Learning System was launched **to provide opportunities for people to learn together and access the expertise of others**, to support improvements in services for people with a diagnosis of personality disorder. It promotes equality and inclusion in its activity.

We hosted a series of **10 virtual webinar and workshop events** that ran from May 2022 to March 2023.

Our **monthly newsletters** kept our network up to date with the latest programme information. We showcased learning from our events, useful resources, and ways to get involved in our work. We also shared snapshots of current good practice in **two case studies**.

All resources including recordings and newsletters can be accessed at https://ihub.scot/improvement-programmes/mental-health-portfolio/personality-disorder-improvement-programme/

PDIP 1 Learning System



Evaluation of the webinars and workshops has shown considerable interest and engagement.

Outcomes suggest that events were found to be **interesting, engaging, and informative** whilst at the same time providing clarity and highlighting areas for future consideration.

Specific areas for improvement were noted such as **language, staff training and education**, and the importance of **lived experience voices and input in improving services**.

The range of topics looked at as part of our learning system were:			
Programme Launch	Integrated Care Pathways	Underserved and often overlooked populations	Diagnosis and formulation
Challenges of diagnosis (CPTSD)	Lived Experience and design of services	Staff development and therapeutic approaches	Stigma
Unscheduled care and out of hours	End of phase one findings	National and international perspective	

Strategic Gap Analysis

All 14 NHS boards provided information about their current service provision through interviews. They highlighted their approaches and challenges, describing significant variation across Scotland. The following gaps between current provision and population need were identified from the Strategic Gap Analysis.

Leadership and system challenges
• A need for a shared and accurate understanding of personality disorders • Greater senior buy is required. • Lack of meaningful involvement from those with lived experience • Limited evaluation and use of data to inform future service design
Staffing challenges
• Stretched workforce combined with volume and complexity of work • Staff turnover, and recruitment challenges, especially for staff with specialist skills. • Limited opportunity for personality disorder specific training for staff.
Service provision limitations
• Variable access to appropriate treatments – lack of timely access to range of interventions • Under-developed or newly developed Integrated Care Pathways leading to inconsistent treatment • Role for virtual service delivery with the added complexity that face-to-face services can be of particular benefit to building the trust and long-term relationships • There are examples of combining trauma and personality disorder care pathways, and of keeping them as separate pathways.

What good looks like

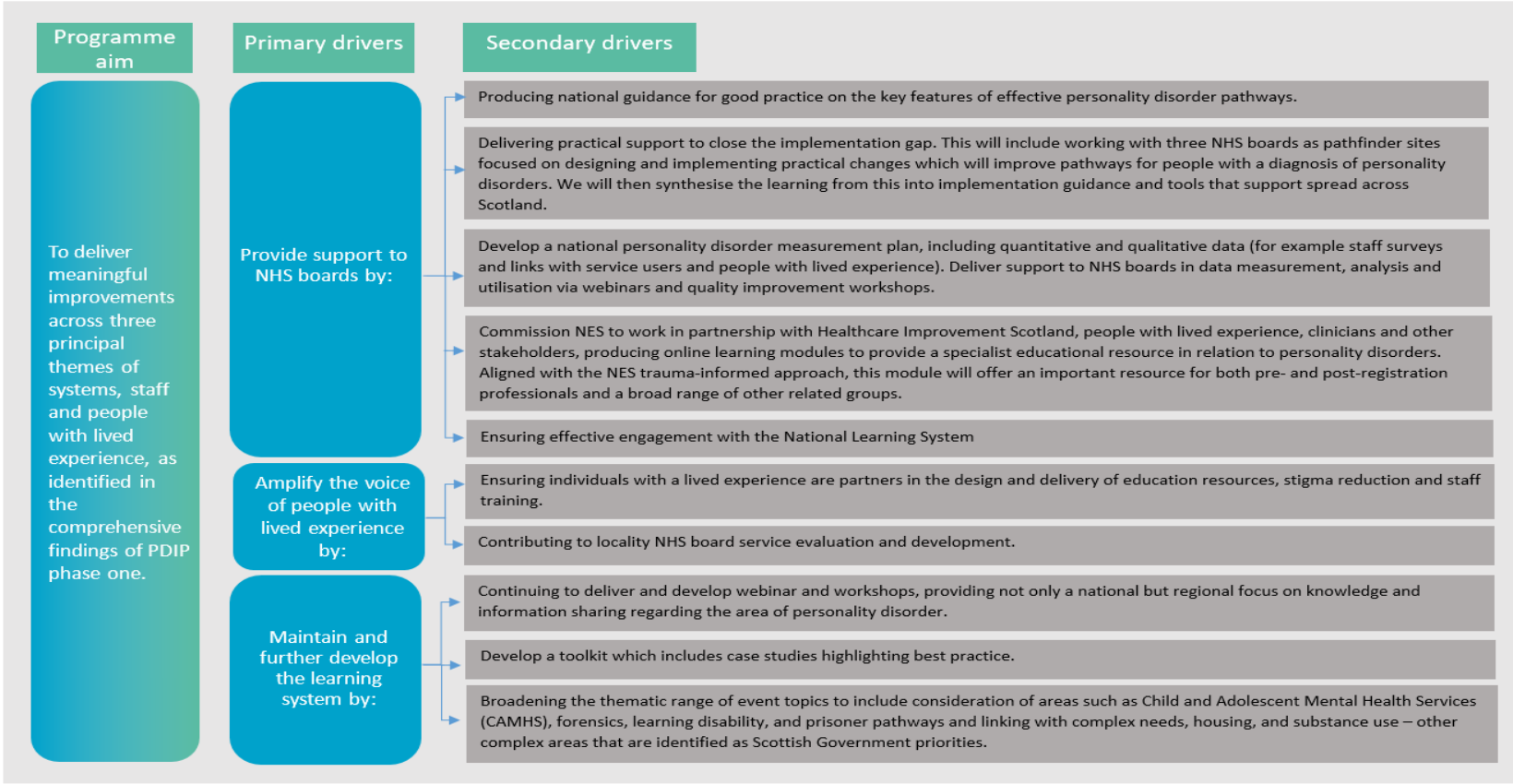
There is no single model of how to deliver all the aspects of good care, but the most coherent and developed pathways include:

- Strategic support and leadership
- Shared vision, clear pathway
- Different interventions for varying levels of severity (stepped/matched care)
- Lived experience input
- Access to relevant staff training
- Co-ordination between different elements and professional groups.

Recommendations for Phase 2

Recommendations for Healthcare Improvement Scotland	Recommendations for local areas
• Develop a data measurement framework. • Deliver an expanded learning system. • Produce a toolkit, including case studies, to support service improvement. • Work with three pathfinder sites to design and implement practical changes improving pathways for people with a diagnosis of a personality disorder. • Commission NES to produce educational resources. • Produce guidance for delivery of care for people with a diagnosis of a personality disorder.	• Engage with the learning system. • Engage with the production and roll out of specialist educational personality disorder resources. • Support the development of national guidance. • Support the development of the data measurement framework. • Consider volunteering to be one of the three pathway boards. • Engage with people with lived experience (PWLE) to support evaluation and development of services.
Recommendations for Scottish Government	**Recommendations for partners working with PWLE**
• Commission HIS for PDIP phase 2 (as outlined in the driver diagram). • Commission third sector organisation(s) to deliver a parallel lived experience component of the work.	• Engage with a wide range of PWLE across Scotland • Engage with existing support organisations (for example SPDN, advocacy and carers groups). • Develop peer support networks. • Engage with boards to support evaluation and development of services.

PDIP Phase 2 Delivery – Driver Diagram



Questions

Keep in touch

his.mhportfolio@ihub.scot

@SPSP_MH

To find out more visit https://ihub.scot/improvement-programmes/mental-health-portfolio/personality-disorder-improvement-programme/

Next Steps

Evaluation

Use the link in the chat box or scan the below

Thank you for joining us – please keep in touch

Twitter: @online_his

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