Personality Disorder Improvement Programme Integrated Care Pathways and Specialist Services in NHS Highland and Greater Glasgow and Clyde - Question and Answer

Tuesday 12 July 2022

Questions for NHS Highland

Question - What would be the rationale as to whether to offer Decider or STEPPs group? Is there thoughts/data that would inform the most suitable intervention for an individual?
Answer – I think essentially if someone has been given a diagnosis of borderline personality disorder, STEPPS is an evidence based treatment for that condition and should be offered, if DBT is not appropriate (which is another evidence based treatment). Obviously there are others however these are the two that are evidence based treatment in NHS Highland. If a diagnosis has been made, it should be an offer of STEPPS, but if the person has problems with emotion regulation and a diagnosis of personality disorder that doesn't meet for the criteria for borderline personality disorder then Decider Skills can be offered. And Decider Skills was introduced in highland as a quality improvement exercise so most people in mental health services with problems with emotional regulation and/or self-management, so I don't think many people would argue that skills training in that shouldn't be part and parcel of our service deliver however there was a large variance in how that was done and the quality of that so that's what Decider is about. It actually has a lot of similarities to the emotional skills coping group that we heard our Glasgow colleagues talking about.
Question - Why is this service not available in Argyll and Bute?
Answer – We all get a slice of money from Scottish Government and this is what we have decided to spend our money on and Argyll and Bute have choose to spend their money on something else.
Question - I notice that there is no psychologist integrated into the team. Is this something that you are considering in the future?
Answer – We have had a psychologist in the past as part of the DBT service, we do have one clinical psychologist at the moment. We work in a very team based way, therefore it's likely that another clinical psychologist would be working as another member of the team and if someone came along and offered us some clinical psychologist time we would be delighted to take it and just have that person working as an integrated part of the team. So we would be delighted if someone came along and gave us some of that resource.

Question - Always keen to hear about NHS Highland good work in this area - I appreciate how beneficial remote access to treatment will be in the Highland area - but I also appreciate there can be huge gains in peer support in some groups - is this a noted issue?

Answer – So we have looked at all of our strands pre and post covid. What we've seen is that the outcomes of patient completers are more or less the same. The attendance of patients who are in long groups, so that's DBT and the day service, so a year and 36 weeks, has actually improved when it's delivered remotely but the short groups, things like the post diagnostic group and the supporting self-management group, it tends to significantly worsen, so you could hypothesis as to why that might be, but that's something that we've seen. So there are pros and cons to it, is what I'm trying to say. Our issue with running groups face to face is the face mask requirement and the difficulty in people accessing the whole nonverbal emotional communication that masks take out of the picture, so we actually feel that the communication is more effective when you can see someone's face online rather than in the room when everyone's got masks on. When the masks go, we would aim to run some sort of blended service I think to keep the remote and rural aspect because some people are having to stay overnight or we are having to stay overnight to access groups. So we are travelling 3-4 hours, staying overnight, going to the group and then travelling 3-4 hours home sometimes for a year and it's a big commitment. So we've started to think about how we do this longer term, it might be one session a month is face to face and the other three weeks they meet remotely but we don't know yet, we will need to work with the people in the service to work out what is best, but that's the feedback we've gotten on that.

Question - Can I ask Highland what extra training have your Advanced Practitioners (RMNs) done?

Answer – I think a wide range of training - one of our Advanced Practitioners IPT supervisor, there's been group radical openness training, Decider licence trainers training, STEPPS training, prolonged exposure training, various supervisor training, trauma training and training in the assessment process. So really quite a wide range of trainings, both within the service and also out with.

Question - Just wondered about education and development of practitioners within the services and out with and within general service provision.

Answer – We do have an ongoing programme of education, that was previously delivered in person and it's now able to be delivered remotely. There was a TURAS module, that's still on TURAS but will be updated (an electronic module that pre-dated covid). We offer training on an open basis, we run introduction to personality disorder training several times a year and that's open to anyone but we will also respond to specific requests for training, so for example we train all of the police probationers who are coming through, we've trained all of the front line police officers here, we've trained all of the mental health officers, we train various specialist registrar groups here, psychiatric training across the country. We are currently discussing training with the perinatal mental health team and the community midwives and health visitors and so on that work with them. So that's just some examples but we are happy to be flexible on that because that serves a function really in terms of the remote and rural working and getting people upskilled and changing attitudes and improving knowledge, so that across the board people are delivering as high quality service as they can to this group of people.

Questions for NHS Greater Glasgow and Clyde

Question - Do you find issues when the full service is not available across the city ie access to certain treatments only available in parts of the city?

Answer – Yes, this can be a problem during the development phase of the pathway. The ambition is to make all therapies available equitably wherever people present in Greater Glasgow and Clyde. However, this is a process of development, and we have had to work pragmatically from what we had in place towards developing what we would ideally want for people accessing services. The first phase of development was to establish equitable access to at least one form of evidence based therapy wherever you are in the health board area; the next phase will be working towards increasing availability and choice.

Question - would be good to hear more about how you have managed to get meaningful lived experience input, what is looks like

Answer – We looked at models in various parts of the UK to inform our development of a lived experience group, hosted by a third sector partner (The Mental Health Network). This allows independence of this group with some support in place, and a direct line of communication between the group and the BPD Implementation Steering Group. We would be happy to share more detail about this. Individual services (for example the DBT service) also have small groups of service users who have completed treatment and who are motivated to contribute towards service development.

The service has representation at the BPD Implementation steering group which is part of the NHS GG&Cs 5 year Mental Health Strategy to support and improve the experience of individuals with a BPD diagnosis by ensuring training for all mental health staff on BPD and improving access to therapies and resources for individuals and their families. A member of the team will also be regularly liaising with the Lived Experience group which is hosted by the Mental Health Network and composed of individuals who have completed STEPPS, DBT or MBT.

This is an area that the Psychological Therapy Groups Service is currently focusing on. Additionally all patients who proceed to group intervention are asked to complete routine outcome measures (ROMs) specific to the intervention being delivered. At minimum, we ask for these to be completed at pre- and post-therapy points. In addition to these clinical outcome measures we ask each group participant to provide qualitative feedback in their experiences of the group intervention at the end of the group. All responses are anonymised. Our ambition is to further develop links with the Mental Health Network to ensure additional avenues of communication to enhance service development.

Question - Is the NHS GG&C ICP publicly available? We are developing our own pathway in West Lothian and have found the Highland Pathway extremely helpful in guiding our thinking

Answer – This is not currently published and available in a single document. There are a number of linked documents in development describing the overall pathway, the training programme for staff and detailed guidance for staff. Some of these are still in development. We would be happy to share any information which might be helpful.

Question - Is there a pathway from ADRS or is the pathway from ADRS always through the CMHT?

Answer – The pathway in Greater Glasgow and Clyde is primarily, at this stage, services within adult mental health. For example, ECS, STEPPS, DBT and MBT could only be accessed via the 18 CMHTs in Greater Glasgow and Clyde. We have examples though where ADRS have worked closely with service users who have become ready to engage with one of the psychological therapies on offer; we then communicate between CMHTs and ADRS to make entry into these therapies possible.

The one day training (CCC) delivery is also hoping to enter a second phase roll out which will include ADRS.

Question - Interested in how delivering ECS remotely has been. Is the digital format well received by patients?

Answer – We have incorporated anonymised feedback from group participants into our service design and currently take feedback using MS Forms at the end of group cohorts. Since we began using this method, 44 ECS participants have given feedback on their experience, including on specific questions around the digital format. A summary of this feedback is outlined below.

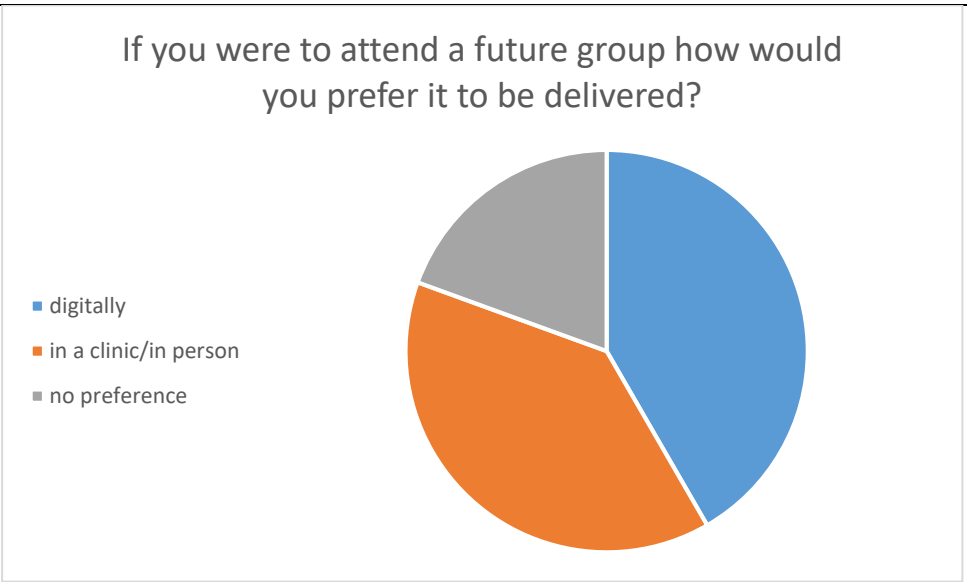
What were the advantages of digital delivery?
The most commonly cited advantages were:

- Reduced the need to travel, and reduced associated costs
- Led to less anxiety about attending
- Easier to fit in around other commitments e.g. work
- Increased comfort and sense of safety of attending from own home

A number of participants highlighted that these advantages were associated with increased attendance and accessibility of the intervention.

What were the disadvantages of digital delivery?
The most commonly cited disadvantages were:

- Connectivity/technical issues
- Less connection and social interaction with other group participants and facilitators
- More distractions when joining from home environment



Question - is there any ambition for the ECS groups to be available to inpatients?

Answer – ECS groups were originally developed by the inpatient psychologists at Leverndale Hospital on the acute psychiatric wards and has been delivered there for a few years already. Currently ECS groups are offered by some inpatient services in Greater Glasgow and Clyde throughout the year. Approximately four cohorts are delivered annually.

This work has been closely evaluated and as a result of the positive outcomes it was decided to develop a digital pack available to all adult mental health services in Greater Glasgow and Clyde. Currently the Greater Glasgow and Clyde Psychological Therapies Groups Service (PTGS) aims to provide evidence-based psychological therapy groups for the 18 CMHTs across Greater Glasgow and Clyde only.

The PTGS is an adjunct intervention service so we require referring teams to provide the wrap around care for patients who are currently engaged in one of our group interventions. As such, we require patients remain open to their referring team throughout their episode of care with the PT Groups Service to ensure access to Multi-Disciplinary Team assessment, care and treatment. Should an admission be necessary during an individual's engagement with the PT Groups service, they may wish to continue to engage in the weekly group or they may decide to join another cohort once their admission has ended. This is determined on a case by case basis. We run groups regularly throughout the year so individuals are not required to endure lengthy waits for a group to start. As the service evolves we also intend to offer psychological therapy group options to other care groups based on presenting need and matching to group offers. Currently ECS groups are offered by inpatient services throughout the year. Approximately four cohorts are delivered annually.

Question - Can the ECS format be shared?

Answer – The copyright covers all Greater Glasgow and Clyde services, so it can be shared within Greater Glasgow and Clyde.

Question - Great to see measure being used...are these being used across all of the services that are delivering psychological interventions for BPD. Or can they be?

Answer – Yes it would be the ambition that the same measures would be used across services when delivering individual or group based interventions for this client group. There is an agreement to use the same core outcome measures in a standardised way across the different therapies, in addition to some specialised measures. It is early days, but we are aiming to improve data collection and reporting across the pathway.

Question - I notice we typically do not diagnose traits of personality disorder or offer these interventions over 65 years of age in GGC. is there still a thought that these traits become less prominent old older adults or is there another clinical basis for this?

Answer – That is an interesting point. I am not sure we have good data on the rates of diagnosis of personality disorder in older adults. Some colleagues have reported seeing an increase in recent years. There is some published evidence that the presentation may be different, but little published that I am aware of about the effectiveness of therapies for the older age group. I think it is an area for further research and understanding.

Question - Would diagnosis be quicker if Family were to be included when assessing patients?

Answer – Yes, this is a very good point. The Greater Glasgow and Clyde training for staff includes guidance on taking a broad approach to assessment, diagnosis and formulation, including involving family and friends with the person's permission.

Question - I am interested to know more of how you include lived experience in the development of your models.

Answer – We looked at models in various parts of the UK to inform our development of a lived experience group, hosted by a third sector partner (The Mental Health Network). This allows independence of this group with some support in place, and a direct line of communication between the group and the BPD Implementation Steering Group. We would be happy to share more detail about this.

This "BPD Dialogues" group has contributed to the model of training for mental health staff, had input on guidance documents for staff, developed a leaflet from a lived experience point of view for people who might be entering services, conducted a social media campaign for BPD awareness month to raise the profile of people with this diagnosis and challenge stigma.

Some individual services also use lived experience voice to influence their particular model, for example the graduate group in the DBT service. We hope to continue to explore the concept of co-design to make service development collaborative with people with lived experience.

Question - when you say treated 14 people, do you mean 14 people completed?

Answer – This question was in the context of speaking about the first year of the DBT pilot. A total number of 14 people completed either a cycle of DBT or a 20 week STEPPS group in that first year of starting the service.

Question - re previous presentation. what was drop out rate re ECS groups please and did people who dropped out get anything else please?
Answer – Individuals may leave a cohort for different reasons. On some occasions it is appropriate to offer another cohort that may be more convenient or starts slightly later in the year. Individuals who start a group and then leave before completing can be re-referred, for any of our group based interventions, by their team in the future if they decide that a group based intervention may be appropriate. ECS can also be delivered on a 1-1 basis by an individual's key worker if the group format is not suitable. Across the 16 ECS cohorts run this year, just under 7% of group members have not completed the course, giving a mean dropout rate of approximately 2 people per cohort.