Healthcare Improvement Scotland | ihub

Personality Disorder Improvement Programme

End of Phase 1 Webinar

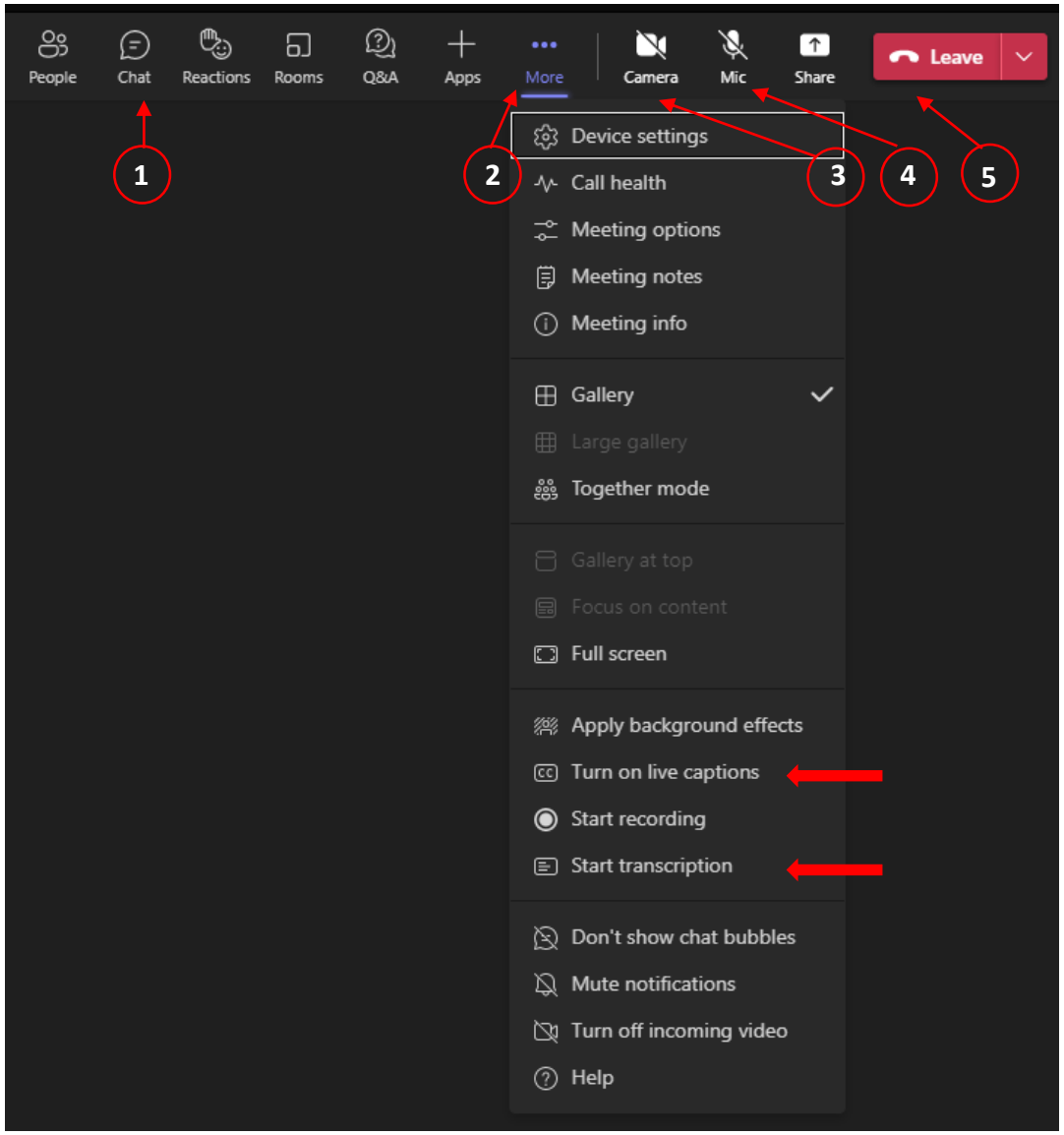
Tuesday 28 March 2023
14:30 – 16:00

@SPSP_MH #PDIPscot

Welcome and introductions

Gordon Hay
Senior Improvement Advisor
Healthcare Improvement Scotland

MS Teams Settings



1. **How to open and close the chat panel** – use the chat panel to introduce yourself, raise any questions you may have for the speakers and also post comments.
2. **Under 'more' you can access some accessibility features** such as live captions and also a live transcript of the meeting (highlighted with the arrow).
3. Your **camera** will be automatically switched **off**
4. Your **microphone** will be automatically switched **off**
5. How to **leave** the meeting

This Webinar will be recorded.

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

Please do not record the session.

Agenda for today

Item No.	Title	Lead	Duration	Time
1.	Welcome	Gordon Hay	5 minutes	2:30 – 2:35
2.	Update on PDIP	HIS Team	15 minutes	2:35 – 2:50
3.	Questions		5 minutes	2:50 – 2:55
4.	Prevention and early intervention for Personality Disorder: An International Perspective	Professor Carla Sharp, University of Houston	20 minutes	2:55 – 3:15
5.	Questions		5 minutes	3:15 – 3:20
6.	SRN/VOX	Hannah Kane	10 minutes	3:20 – 3:30
9.	Questions		15 minutes	3:30 – 3:45
10.	Reflections from PDIP	Rachel King	15 minutes	3:45 – 4:00
11.	Close			4:00

Staff engagement and learning system evaluation

Ashling McCallion
Social Researcher

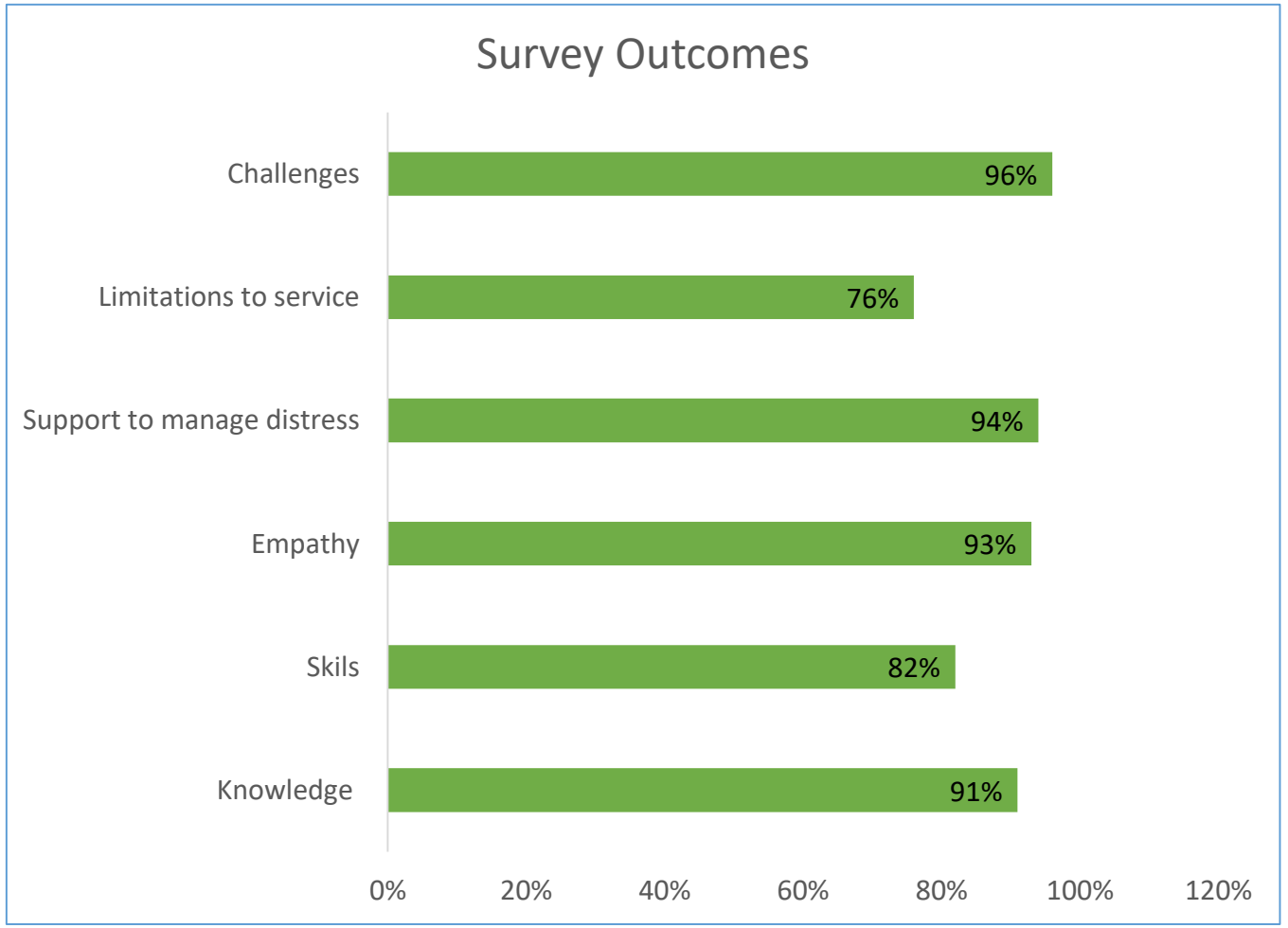
Staff Engagement

- 303 staff took part
- Survey open from June to October
- Nurses had greatest representation
- 19 one to one staff interviews

Survey Outcomes

Staff felt that they had:

- Knowledge
- Skills
- Empathy
- Staff felt that people can be supported to manage their distress
- Staff overwhelmingly felt there were challenges and limitations



Challenges and limitations

Interview Outcomes

Barriers to high quality care

Diagnosis and diagnostic language

Access to training and job satisfaction

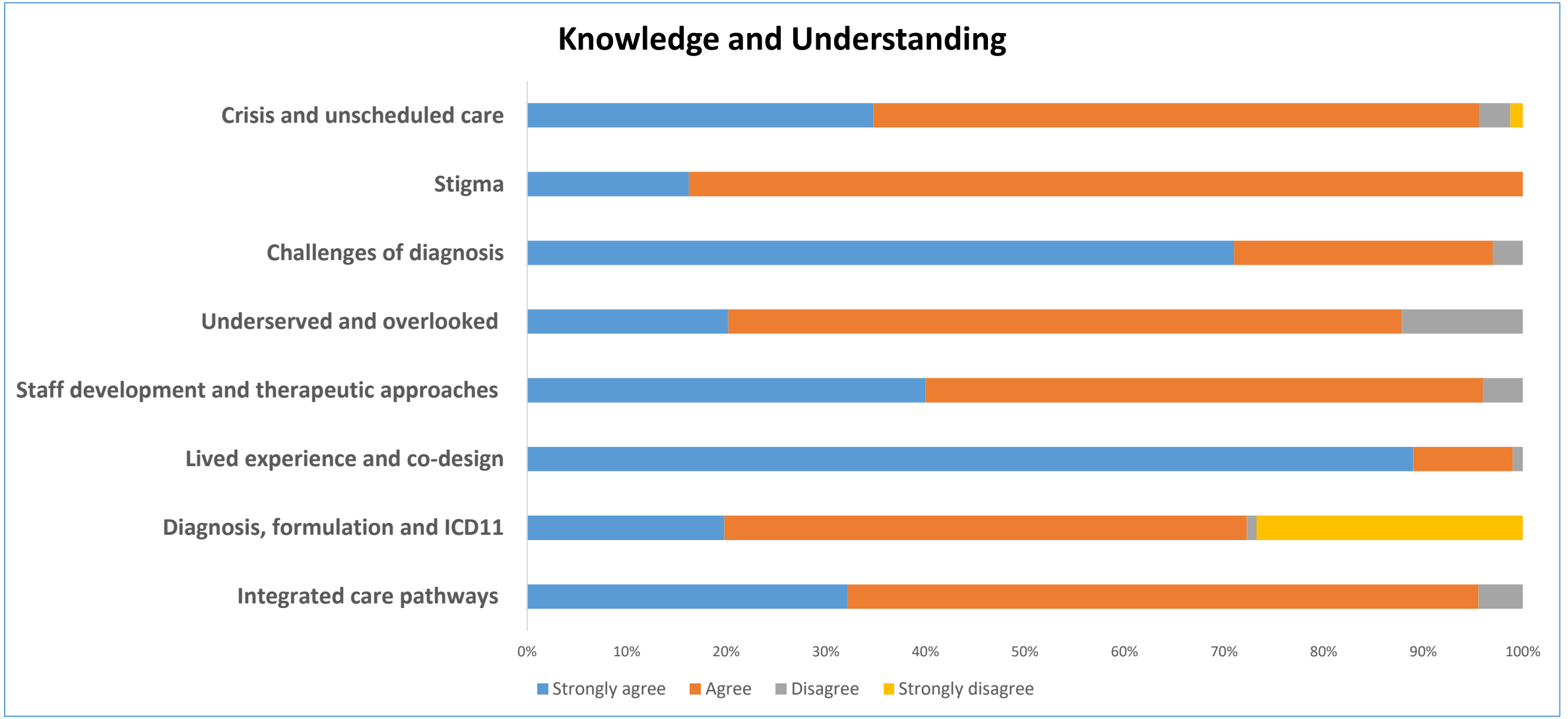
Stretch on staff and managing relationships

Service design challenges

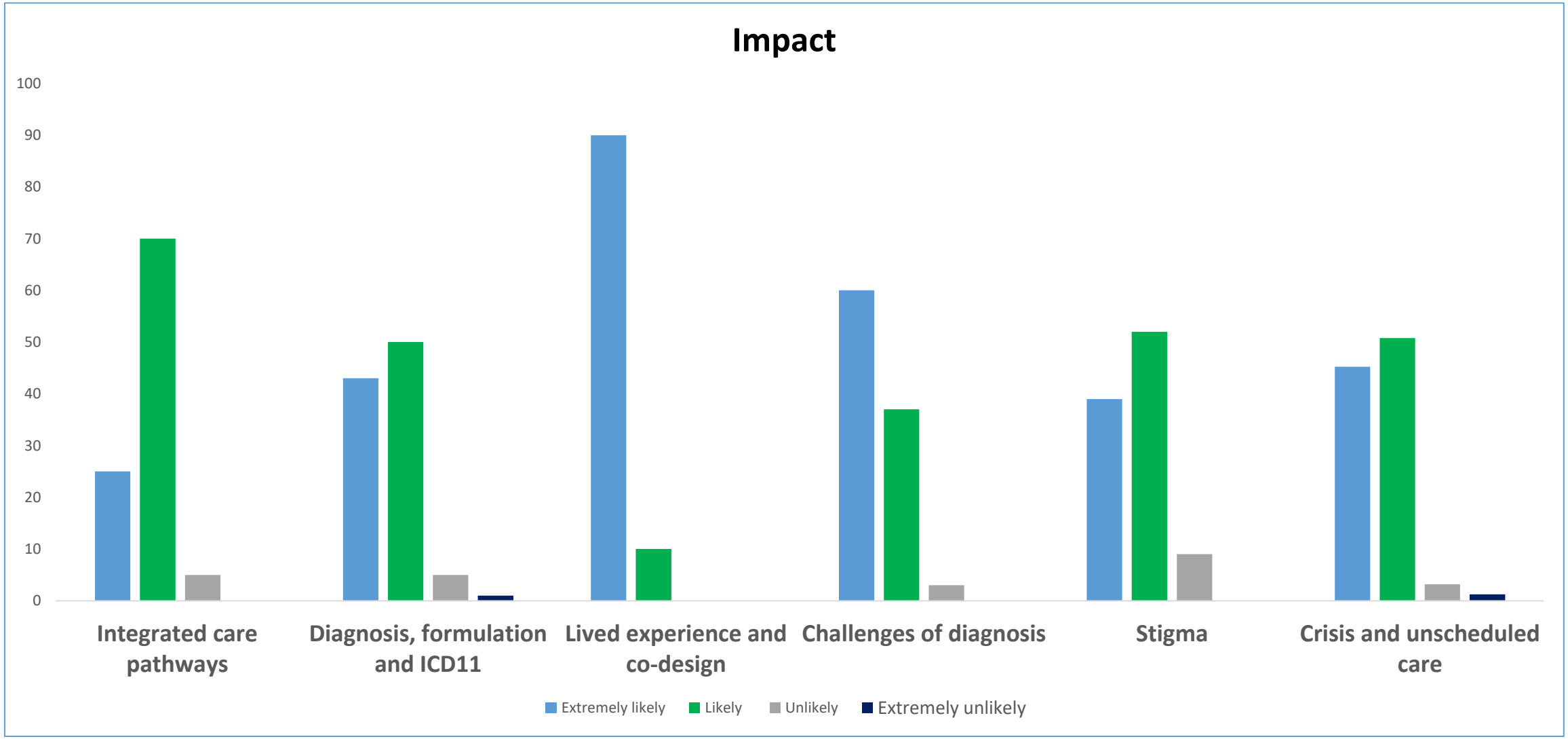
Learning system evaluation

- Significant interest
- Significant engagement
- Over 1,600 people have attended
- Average attendance of 200

Learning system evaluation



Learning system evaluation



What we heard from the Health Boards and HSCPs

Dr Michele Veldman and Dr Andy Williams

Clinical Leads for PDIP

A 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.

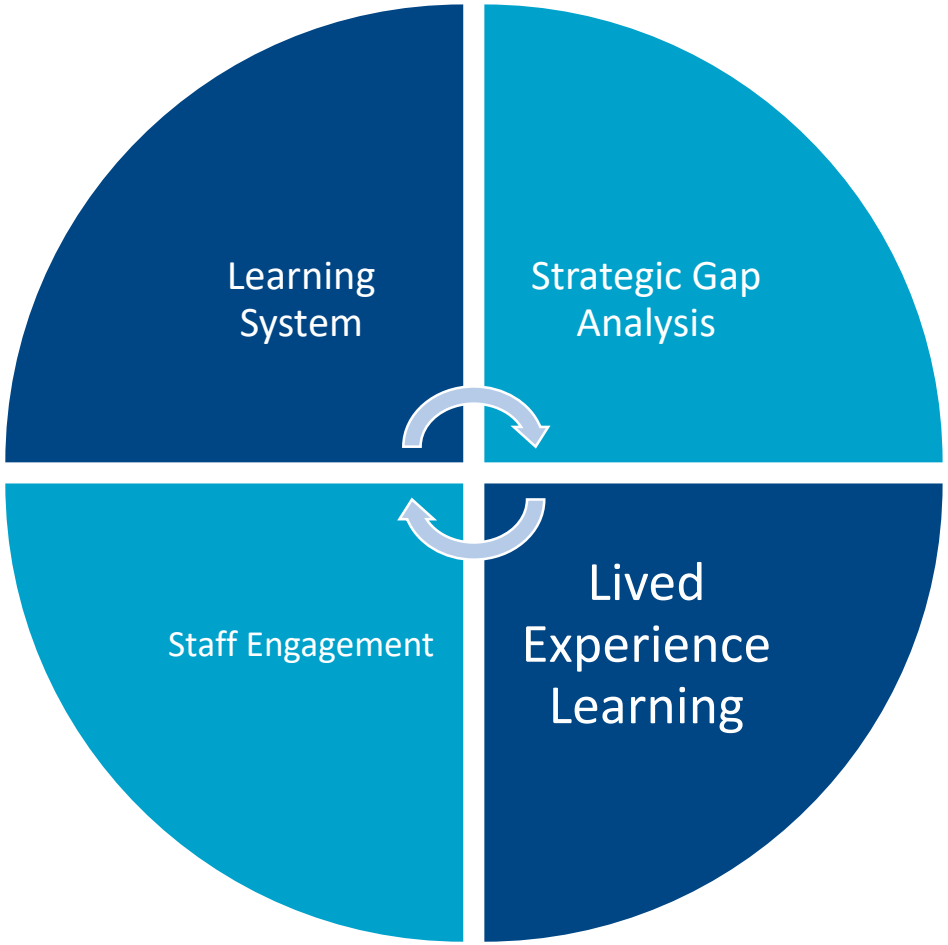
Within the PDIP programme of work, we recognise that this debate can be contentious and polarising. The aim is to respect these differences, whilst carrying out the work of reporting our findings on current services in Scotland and areas for improvement.

Setting the Scene

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. This report was enabled by colleagues from the third sector, those with lived experience, mental health staff and all 14 NHS boards.

Work by the **Royal College of Psychiatrists (2018)** and the **Mental Welfare Commission (2018)** highlighted significant variation and disparity in provision, quality and access to care and services across Scotland for those with a diagnosis of personality disorder.

Core Components of the programme



Understanding the landscape of current service provision played a key role in the programme's activity. PDIP worked to establish connections across professions:

- Virtual locality visits with all 14 NHS Scotland health boards and associated health and social partnerships.
- Gap Analysis report completed by Strategic Planning colleagues.

The level of engagement and interest in this topic across all of the boards, professional groups, third sector and staff groups has been extremely positive - this is a finding in itself.

Strategic Gap Analysis Themes:

Systems

- Numerous pockets of good innovative effective work, for example pathways, therapeutic interventions and engagement with people with lived experience.
- Evidence of high level thinking and awareness, even if not fully implemented.
- COVID-19 has been significant with boards not being able to deliver their previous plans and or changed how services are delivered.
- Disparities within individual health board areas and differences between HSCP.
- Finance - different budgets/ lack of ring-fenced budgets.
- Evidence of cross fertilisation across Scotland – good practice influencing other good practice, however absence of a good sustainable learning network.

Strategic Gap Analysis Themes:

Staff

- Impact of staffing and stretch on workforce, combined with volume and complexity of work.
- Evidence of senior clinicians who are making things happen. Organisational support reinforces the effectiveness of these leadership roles.
- Issues around access to and sustainability of the rolling out of training and development.
- Equity in access to training in the lower intensity interventions

People with lived experience

- Most boards reported intentions or plans to engage more with those with lived experience, families and carers to inform service improvement, redesign and delivery
- Several boards worked with people with lived experience to design training for staff
- Peer workers are not routinely employed – highlighted as a potential area for development

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 sharing of a vision/pathway in an area
- 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.

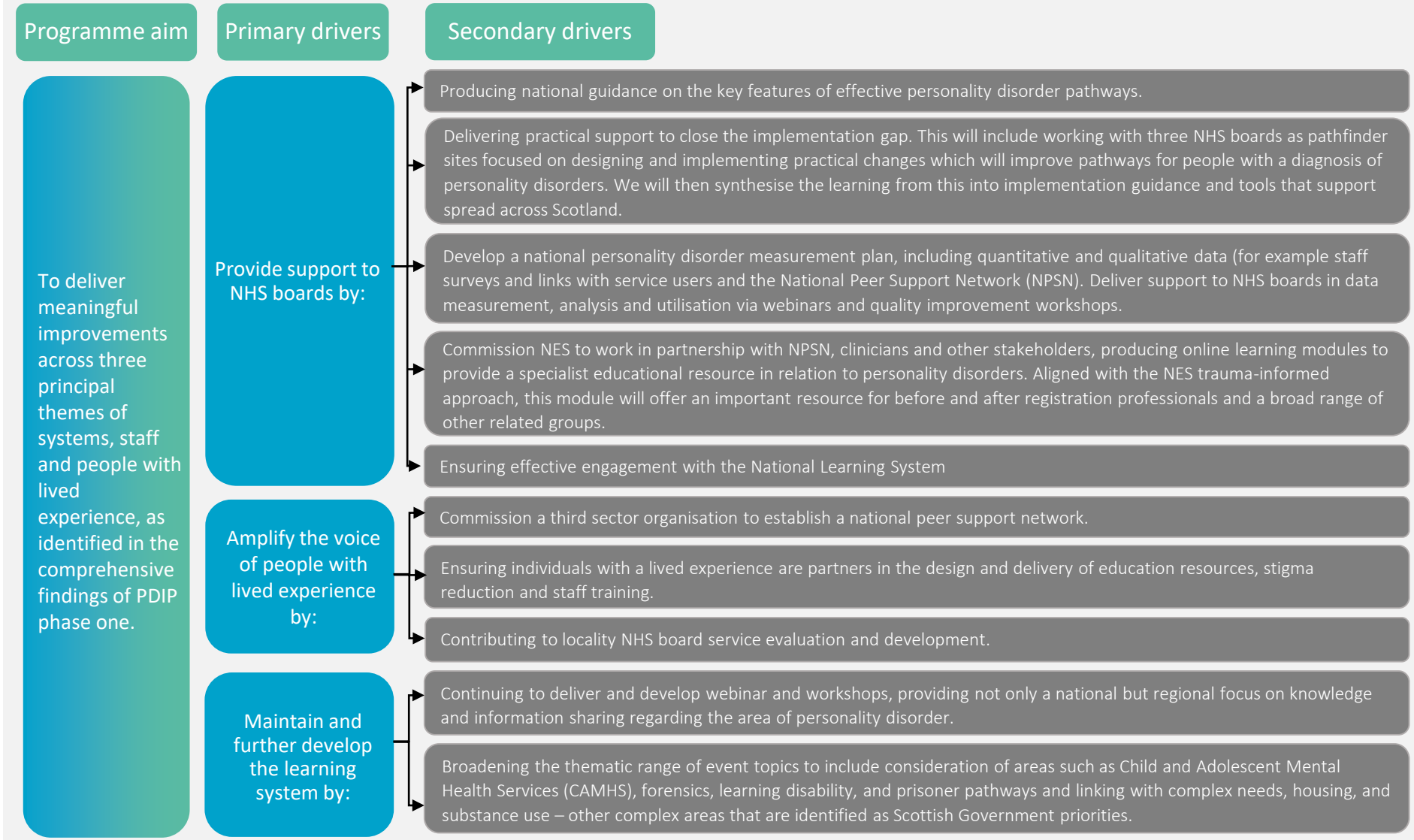
Update on PDIP

Gordon Hay
Senior Improvement Advisor
Healthcare Improvement Scotland

Outcomes and Recommendations

- Lived Experience
- Staff Development
- Service Development

PDIP Phase Two Driver Diagram



Learning System – expanded focus

- CAMHS
- Primary Care
- Learning Disability
- Substance Use
- Forensic
- Prisoner Health
- Older Adults
- A&E

Q&A Session

Prevention and early intervention for Personality Disorder: An International Perspective

Carla Sharp

The Global Alliance for Prevention and Early Intervention for BPD

Prevention and early intervention for borderline personality disorder: a novel public health priority

There is now a broad evidence-based consensus that borderline personality disorder (BPD) is a reliable, valid, common and treatable mental disorder[1]. The adverse personal, social and economic consequences of BPD are severe. They include persistent functional disability[2], high family and carer burden[3], incomplete

in May 2014. The Alliance calls for action through a set of scientifically based clinical, research and social policy strategies and recommendations.

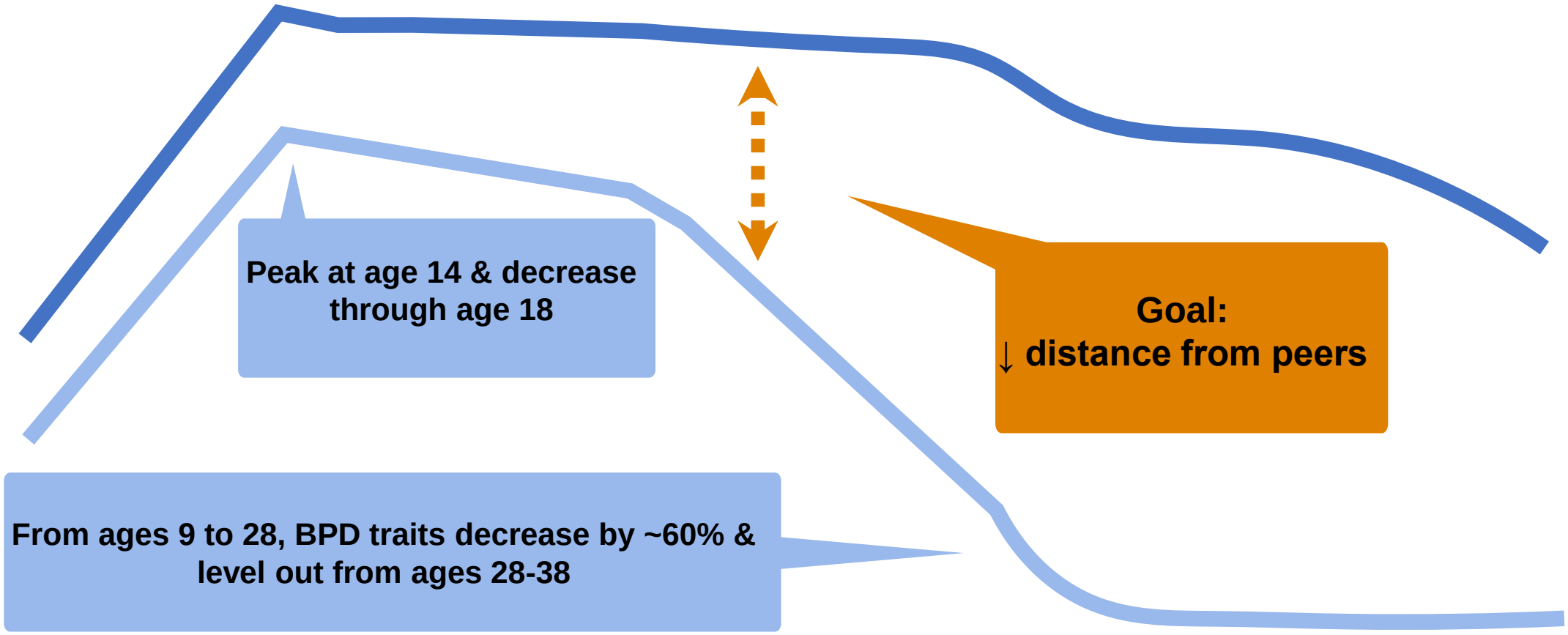
Clinical priorities include: a) early intervention (i.e., diagnosis and treatment of BPD when an individual first meets DSM-5 cri-

Chanen, Sharp, Hoffman et al. (2017) *World Psychiatry*

Biases (myths)

1. Psychiatric nomenclature does not allow the diagnosis of PD in adolescence.
2. Certain features of BPD are normative and not particularly symptomatic of personality disturbance.
3. The symptoms of BPD are better explained by traditional Axis I disorders.
4. Adolescents' personalities are still developing and therefore too unstable to warrant a PD diagnosis.
5. Because PD is long-lasting, treatment-resistant and unpopular to treat, it would be stigmatizing to label an adolescent with BPD.

Sharp (2017), *Archives of disease in childhood*



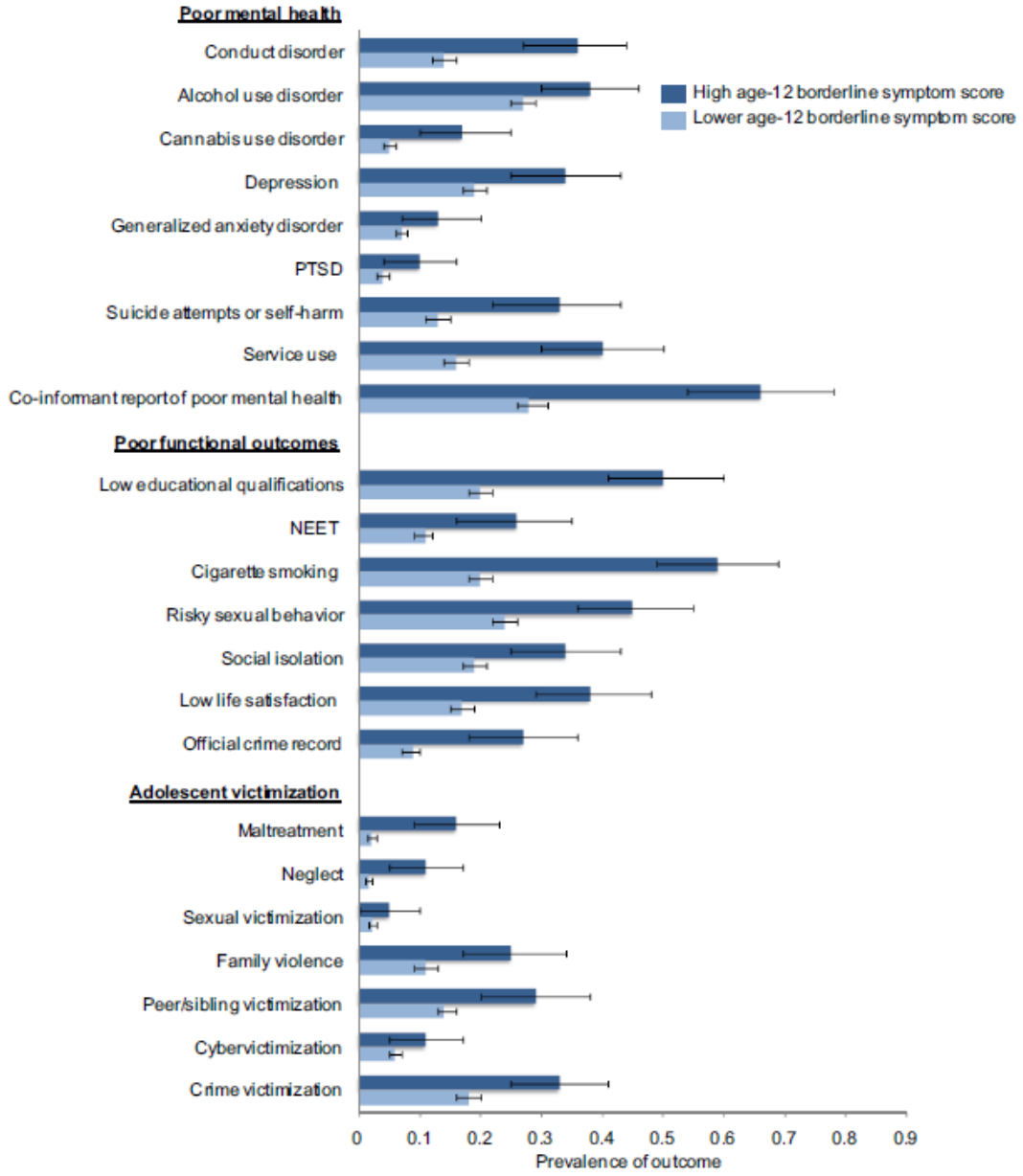
Johnson et al. 2000; Stepp et al. 2014; Haltigan et al. 2016

Measure	Internal consistency	Inter-rater reliability	Factor structure	Construct validity
CI-BPD **Zanarini (2003)**	.81	.65-.93	Not reported	
Sharp et al. (2012)	.80	.89	Unidimensional	Associates with PAI-BOR, clinician diagnosis, BPFS-C, BPFS-P, internalizing and externalizing problems
Michonski et al. (2013)	.78	Not reported	Unidimensional	N/A
SWAP-A-II **Westen et al. (2005)**	Not reported	.60	Not reported	r = .68 with DSM-5 symptom count AUC = .84
PAI-A BOR **Morey (2007)**	.85-.87	N/A	Four-factor	Associated with range of other BPD relevant pathology
BPFS-C **Crick et al. (2005)**	.76	N/A	Not reported	Associates with relational aggression, cognitive sensitivity, emotional sensitivity, friend exclusivity over time
Chang et al. (2011)	.88	N/A	Not reported	Sensitivity .85 Specificity .84
BPFS-P **Sharp et al. (2013)**	.90	N/A	Not reported	Correlates with BPFS-C, internalizing and externalizing problems
BPFC-11 **Sharp et al. (2014)**	.85	N/A	Unidimensional	Sensitivity .740 Specificity .714

Measure	Internal consistency	Inter-rater reliability	Factor structure	External validity
MSI-BPD **Chanen et al. (2008)**	.78	N/A	Not reported	Sensitivity .68 Specificity .75
BPQ **Chanen et al. (2008)**	.92	N/A	Not reported	Sensitivity .68 Specificity .90
Minnesota BPD scale **Bornavolova et al., 2009**	.81	NA	Not reported	Correlates with PAI-BOR Mean difference for clinical vs. community sample
DIPSI **DeClercq et al., 2006**	Not reported	NA	27 facets ordered into 4-factor structure	Resembles factor structure of adult personality pathology; cross-sectional and prospectively predictive of key outcomes.
MMPI-adolescent version **Archer, et al., 1995**	.43 (5) .90 (F)	NA	14 factors (item level); 8 factors (scale level)	Good congruence between MMPI and MMI-A code types; minimal support for diagnostic BPD profile, but useful for differential diagnosis.
PID-5 **DeClercq et al., 2012**	>.80 for 16 out of 25 facets	NA	25 facets; 5 factor	Fair similarity between this and PID-5 factor structure observed in US adult sample as well as US and Flemish students; Correlates with DIPSI

Sharp & Fonagy (2015) JCPP

FIGURE 2 Prevalence of Mental Health Outcomes Among Study Members With High vs Lower Borderline Symptom Scores at Age 12

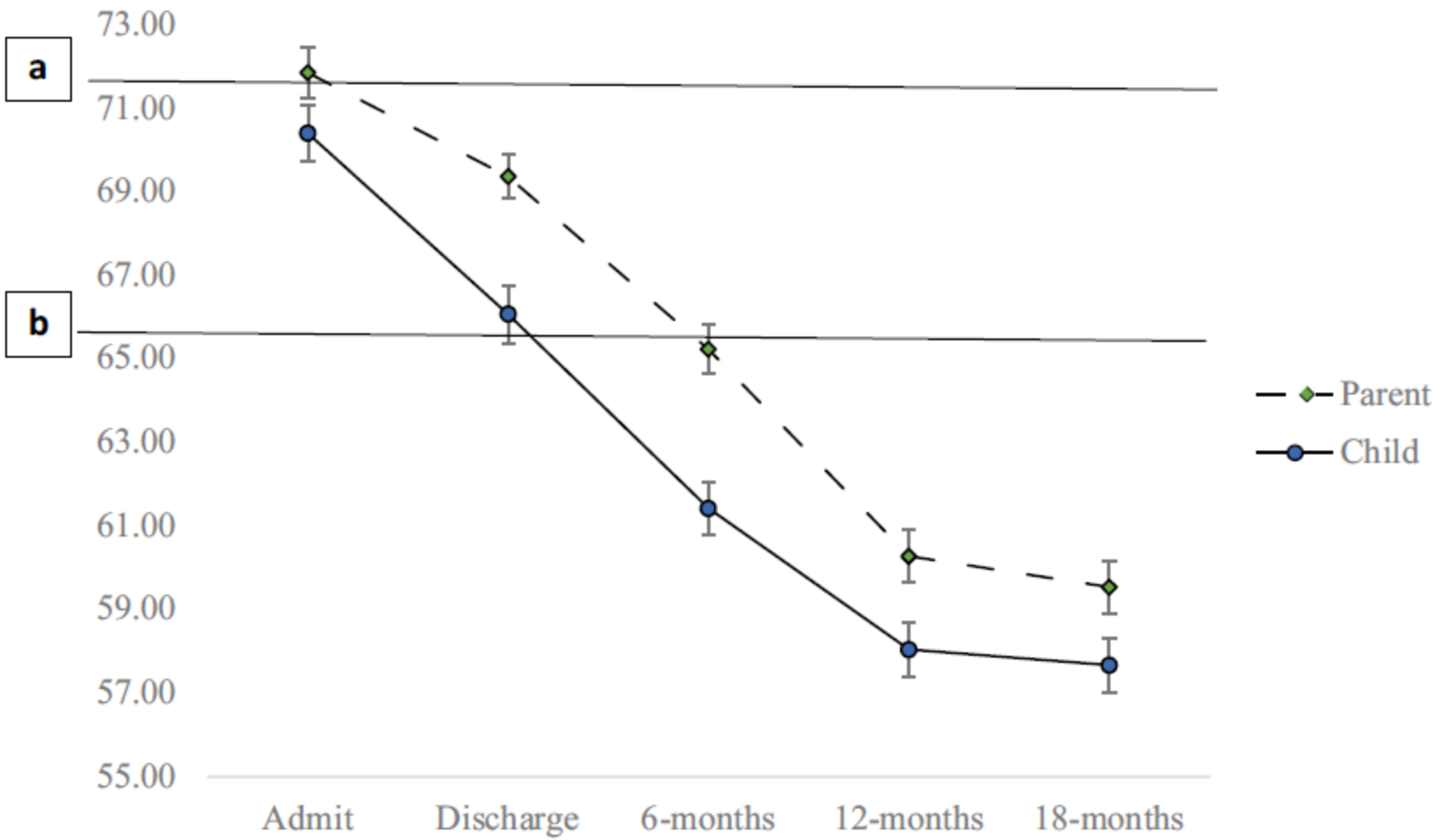


Wertz et al. (2020) *JAACAP*

E-Risk Longitudinal Twin Study
2,232 British twin children
Age 12 mothers rated borderline symptoms

Easily jealous
Falls for new friends intensely, expects too much too quickly
Changes friends constantly, loves them one day and hates the next
Fears they will be rejected or abandoned
Feels others are out to get him/her
Acts overly seductive or sexy, flirts a lot
Attracted to unsuitable romantic partners
Emotions spiral out of control, has extremes of rage, despair, excitement
Cannot think when upset, becomes irrational
Unable to soothe or comfort self
Lacks stable image of self, changes goals/values
Expresses emotions in an exaggerated dramatic way
Irritable, touchy, or quick to "fly off the handle"
Angry and hostile
Engages in self-harm behavior

Fig. 1 Course of BPD features in the full sample from admission to 18-months post-discharge. **a** clinical cut-off for parent report, **b** clinical cut-off for adolescent self-report



Sharp et al. (2020), JRCAP

Biases (myths)

1. Psychiatric nomenclature does ~~not~~ allow the diagnosis of PD in adolescence.
2. While certain features of personality pathology are normative, some young people do not grow out of symptoms and features are then symptomatic of personality disturbance.
3. The symptoms of personality pathology are not better explained by traditional Axis I disorders.
4. Personality is relatively stable across development and there are valid and reliable tools to diagnose personality disorder in adolescents.
5. Personality challenges do improve in response to treatment and those with lived experience ask us to help identify the underlying problem to it can be treated.

Child and Adolescent Mental Health

Child and Adolescent Mental Health 28, No. 1, 2023, pp. 186–191 doi:10.1111/camh.12618

Commentary: Commentary on the Twitter comments evoked by the May 2022 debate on diagnosing personality disorders in adolescents

Marialuisa Cavelti[1], Carla Sharp[2], Andrew M. Chanen[3,4] & Michael Kaess[1,5]

[1] *University Hospital of Child and Adolescent Psychiatry and Psychotherapy, University of Bern, Bern, Switzerland*
[2] *Department of Psychology, University of Houston, Houston, Texas, USA*
[3] *Orygen, Melbourne, Victoria, Australia*
[4] *Centre for Youth Mental Health, University of Melbourne, Melbourne, Victoria, Australia*
[5] *Department of Child and Adolescent Psychiatry, Centre for Psychosocial Medicine, University of Heidelberg, Heidelberg, Germany*

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Current Opinion in Psychology

Moving forward: closing the gap between research and practice for young people with BPD

Åse-Line Baltzersen

The study of personality disorders has come a long way, and this is characterized by the optimism prevalent within the community dedicated to its study. Outside this community — delays in intervention, ostracism, and ignorance remain common place. With a significant burden of disease and high costs at individual, social, and societal levels there is an urgent need to translate research into practice. Proposed solutions include educating the workforce to improve attitudes and developing more sustainable treatment alternatives. This paper brings forward a user perspective on the need to close the gap between what we know from research and what is done in policy and clinical practice.

Address

diagnoses [1,7••]. Striking a balance between care and stigma remains a key challenge in this area [1,7••,8]. Patients, unlike some clinician accept a personality disorder diagnosis positively as it contributes to identifying disease, rather than negative aspects of themselves [7••]. Moreover, delay in treatment increases the likelihood of a vicious cycle of functional impairment, disability, and therapeutic nihilism [9]. Thus, late intervention and the gap between research and clinical practice can have deleterious effects on individual, social, and societal levels. Emphasizing the high prevalence of BPD, Chanen [10] and others emphasize the need for early intervention within healthcare services, suggesting work on two levels:

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Current Opinion in Psychology

Personality challenges in young people: From description to action

Carla Sharp, Andrew Chanen and Marialuisa Cavelti

Current Opinion in Psychology 2021, **37**:iv–viii

This review comes from a themed issue on **Personality Pathology: Developmental Aspects**

Edited by **Carla Sharp**, **Andrew Chanen** and **Marialuisa Cavelti**

https://doi.org/10.1016/j.copsyc.2021.02.006

The field of developmental personality pathology has been dramatically transformed over the last 15 years. Early proponents of the notion that personality disorder does not magically appear at age 18 years included Paulina Kernberg [1], Joel Paris [2], Efrain Bleiberg [3], Patricia Cohen, and Drew Westen [4], among others. In 2008, Andrew Chanen, one of the guest editors of this issue published an article titled "Personality disorder in adolescence: The diagnosis that dare not speak its name" which provided an unapologetic statement on the necessity of prevention and early intervention and the urgent need to confront the perpetuation of stigma of personality disorder arising from avoiding its diagnosis in young people [5]. Around the same time, special issues on the topic appeared in *The Canadian Journal of Child and Adolescent Psychiatry* [6], *Development and Psychopathology*

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Current Opinion in Psychology

Barriers to care for adolescents with borderline personality disorder

Kiana Wall, Sophie Kerr and Carla Sharp

Available online at www.sciencedirect.com

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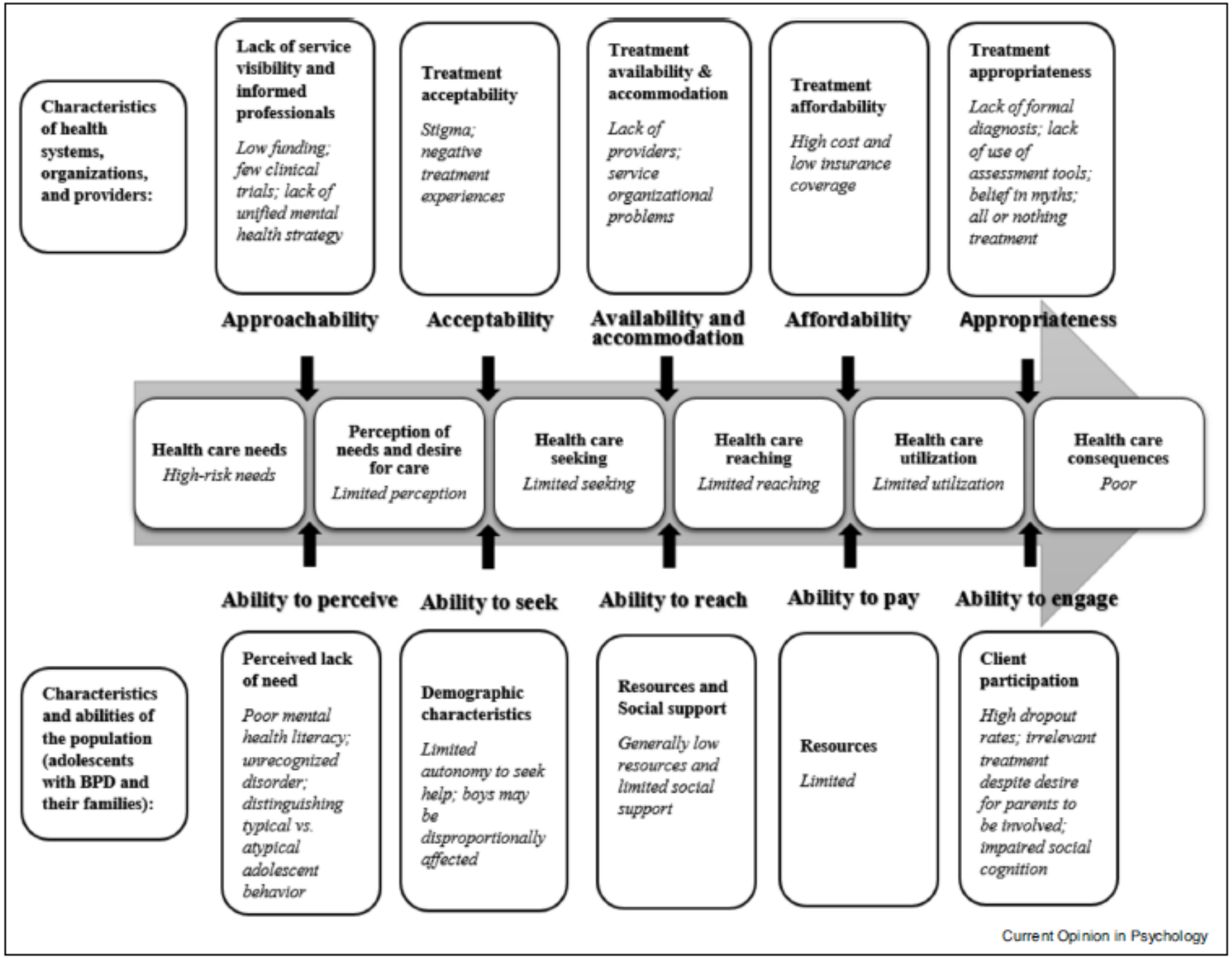
Current Opinion in Psychology

Review

Five failures and five challenges for prevention and early intervention for personality disorder

Andrew M. Chanen[1,2] and Katie Nicol[1,2]


Characteristics of health systems, organizations, and providers:
Lack of service visibility and informed professionals
Low funding; few clinical trials; lack of unified mental health strategy
Treatment acceptability
Stigma; negative treatment experiences
Treatment availability & accommodation
Lack of providers; service organizational problems
Treatment affordability
High cost and low insurance coverage
Treatment appropriateness
Lack of formal diagnosis; lack of use of assessment tools; belief in myths; all or nothing treatment
Approachability
Acceptability
Availability and accommodation
Affordability
Appropriateness
Health care needs
High-risk needs
Perception of needs and desire for care
Limited perception
Health care seeking
Limited seeking
Health care reaching
Limited reaching
Health care utilization
Limited utilization
Health care consequences
Poor
Ability to perceive
Ability to seek
Ability to reach
Ability to pay
Ability to engage
Characteristics and abilities of the population (adolescents with BPD and their families):
Perceived lack of need
Poor mental health literacy; unrecognized disorder; distinguishing typical vs. atypical adolescent behavior
Demographic characteristics
Limited autonomy to seek help; boys may be disproportionally affected
Resources and Social support
Generally low resources and limited social support
Resources
Limited
Client participation
High dropout rates; irrelevant treatment despite desire for parents to be involved; impaired social cognition
Current Opinion in Psychology

Journal of Personality Disorders, 37(1), 1–15, 2023

ATTITUDES, CLINICAL PRACTICES, AND PERCEIVED ADVOCACY NEEDS OF PROFESSIONALS WITH INTERESTS IN PERSONALITY DISORDERS

William D. Ellison, PhD, Steven Huprich, PhD, Alex Behn, PhD, Marianne Goodman, MD, Sophie Kerr, MA, Kenneth N. Levy, PhD, Sharon M. Nelson, PhD, Carla Sharp, PhD, and the Board of Directors of the International Society for the Study of Personality Disorders

TABLE 3. Perceived Advocacy Needs Related to Personality Disorder Practice

	Adults			Adolescents		
	n	*M*	*SD*	*n*	*M*	*SD*
Patients' needs	275	6.09	1.22	178	6.17	1.35
Service availability and accessibility	275	6.26	1.25	178	6.30	1.33
Insurance coverage	263	5.55	1.95	174	5.60	1.92
Funding for research	273	6.15	1.20	176	6.14	1.41
Promoting utility of PD diagnosis	271	5.84	1.40	176	5.84	1.52

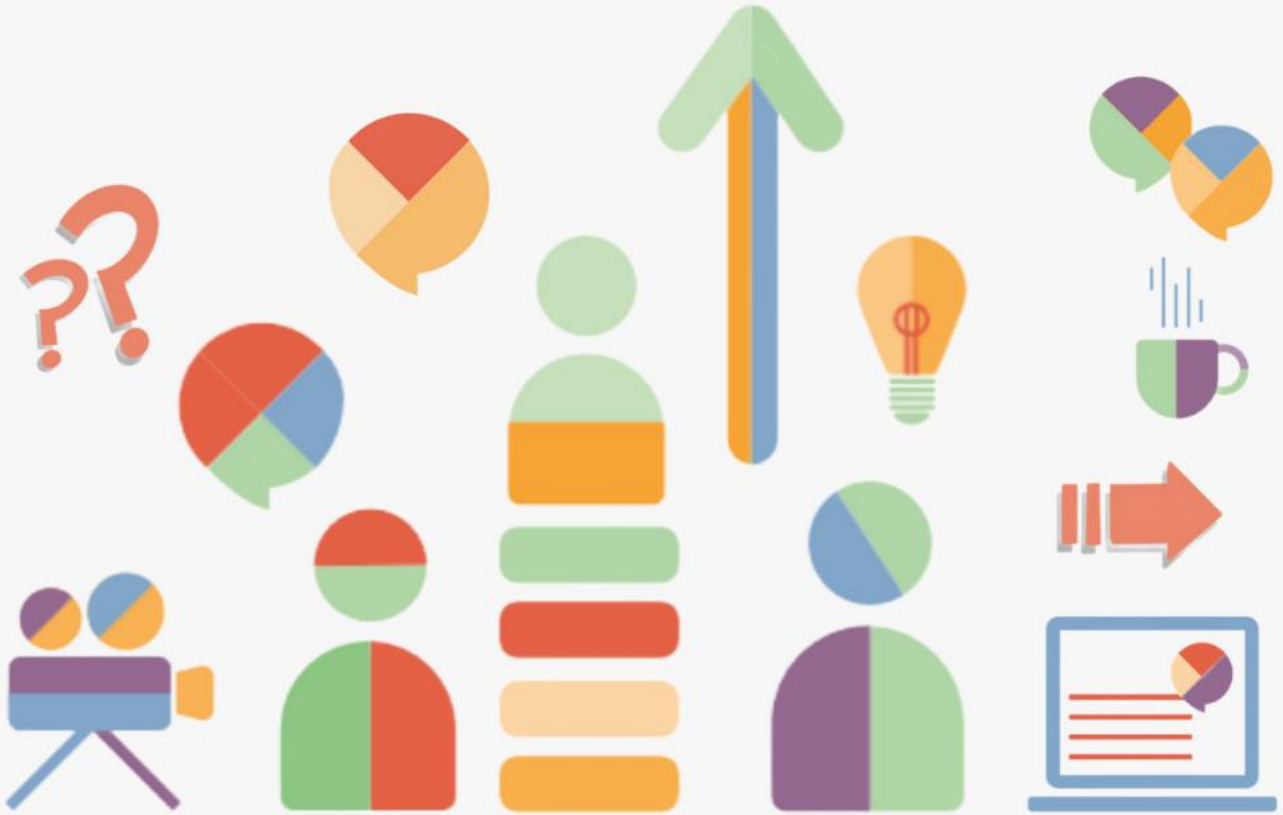
Note. Sample sizes differ slightly because some respondents did not answer every question. Respondents used a 1 (*Not at all*) to 7 (*Very Much*) scale to answer whether better advocacy was needed for personality disorders in these domains.

Thank you!

csharp2@uh.edu

Q&A Session

With Us, For Us



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Scottish Recovery Network

Key Stages

Reach out

- Identify key people, groups, and organisations
- Lived experience research
- Lived experience project group

Conversations

- Hear people's experiences and views
- Different ways to get involved
- Key themes identified and shared

Co-Design

- Bringing lived experience and services together
- Develop understanding of key themes
- Produce options or proposals

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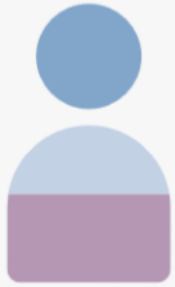
Scottish Recovery Network

A picture of current services

Stigma and Discrimination



Negative impacts of receiving support

Poor experiences of receiving a diagnosis

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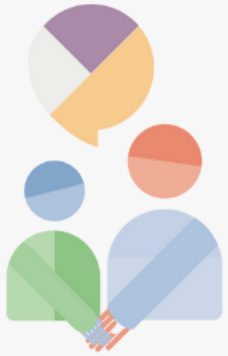
What makes a great service

A Flexible Approach



Compassion

A Relational Focus

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What needs to change

Trauma-responsive

Collaboration • Safety • Trust & Transparency

Peer Support

Powerful • Safe Spaces • Shared Experiences

Whole person, whole system

Connections • Supporters • Treatment Options

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Proposals for change

Peer-led support

Whole person, whole system care pathways

Co-designed and co-delivered training

A new approach to crisis support

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Lived Experience Project Group

Fortnightly meetings

1-1 support

Learning opportunities

Project support

"I felt like my words and opinions were heard and given weight throughout the project...I also felt valued and invested-in as a participant."

“Putting the human element to it, it’s part of a bigger project but this group has brought the human element to it."

“We empathise and relate to each other more than academic research. Because if we don’t connect and relate to each other then we won’t get the best out of it.”

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Outputs

Reports

Photography booklet

Practice learning resource

Animation

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Thanks for listening!

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Q&A Session

Reflections from PDIP

Rachel King
Portfolio Lead
Mental Health Improvement Portfolio

Next steps and keep in touch

Follow up email will be circulated shortly. However if you have any queries, please get in touch with the team: his.mhportfolio@nhs.scot

@SPSP_MH

To find out more visit

https://ihub.scot/improvement-programmes/mental-health-portfolio/personality-disorder-improvement-programme/