An inclusive approach to personality disorders

For many years people with personality disorder have been socially excluded from both mental health services and the wider system, including criminal justice, housing and employment services (Sampson et al, 2006). As it is widely recognised that awareness of personality disorder is limited in both mental health and multi-agency services, a new approach to caring for people with this diagnosis is needed.

What is personality disorder?
The World Health Organization defines personality disorder as “deeply ingrained and enduring behaviour patterns that manifest themselves as inflexible responses to a broad range of personal and social situations” (WHO, 1992). Some common symptoms include:
- Overwhelming negative emotions;
- Avoidance of people or situations (feeling disconnected);
- Difficulty managing negative emotions without engaging in behaviours that are deemed risky, such as self-injury, substance/alcohol misuse, overdosing, hostility and/or aggressive behaviour;
- Relationship difficulties, including making relationships and maintaining healthy, stable relationships;
- Loss of reality;
- Offending behaviours (Sampson et al, 2006).

Personality disorder can be viewed as being on a mental health continuum; people with personality disorder can have periods of mild, moderate or severe symptoms. Recovery can be achieved and many people with this diagnosis report remissions (Livesley, 2001).

Believed to develop in response to early life experiences, personality disorder often becomes apparent during adolescence, with symptoms continuing into adulthood. Genetic background, negative experiences in childhood – such as neglect, feelings of abandonment or lack of stable attachments and abuse – are also thought to be causative factors (Sampson et al, 2006).

Policy on personality disorder
Various government backed policies and publications have supported the need to raise awareness of personality disorder – particularly in agencies providing services such as health and social care, employment and criminal justice – and to develop more effective responses and treatments for
Setting up the strategy

After appointing a senior mental health nurse to lead this initiative, the first task was to identify and engage multi-agency practitioners from services most likely to come into contact with people with personality disorder. We identified key services by following the commissioner guidance (DH, 2009a), and by looking at areas known to have high co-morbidity prevalence rates of personality disorder, including homelessness services, drug and alcohol services, criminal justice and general healthcare. We also sought to include youth services as a way of ensuring that early and timely interventions would be considered for people with emerging personality disorder (DH, 2009b).

Our model relied on a multi-agency training roll-out, delivered collaboratively by both “experts by experience” (EBEs), who have lived experience of personality disorder, and “experts by occupation” (EBOs), who have occupational experience of personality disorder. The strategy lead explained the initiative’s vision to relevant agencies; these agencies recognised the potential positive impact on staff, service users and service effectiveness, and agreed to become partners in the strategy. Engaging with all the agencies required the strategy lead to build ongoing partnerships, part of which involves understanding the needs of specific partner agencies in relation to working with people who present with personality disorder.

Recruiting experts

We recruited EBOs from key partner agencies. There was a high representation of nurses, who came from mental health, learning disability, forensic, management, walk-in, primary care, commissioning, and accident and emergency services. Finding EBOs with the desire to learn more about personality disorder and a genuine interest and empathy for this client group was paramount to the success of the strategy. This was accomplished by selling the model to partner-agency managers, who then helped us to find practitioners with an interest in this area and the right knowledge and attitudes.

Once our EBOs were identified, the lead harnessed their enthusiasm to champion and drive the strategy as members of a virtual team, and to take personality disorder awareness training back to their own workplaces. Within 18 months we had established a one-of-a-kind, dedicated and effective virtual team of EBOs and EBEs at no financial cost to the strategy.

Partnership working

Our secondary service personality disorder hub’s “working-together” protocol has been vital to the success of our partnership working. We developed the protocol in collaboration with EBOs from the 5 Boroughs Partnership Trust’s Personality Disorder Hub Service and the Wigan Multi-Agency Personality Disorder Strategy. It uses a flowchart system to clearly explain what is expected of everyone involved and what to do in times of concern.

The EBE representatives have reported benefits from being involved in the initiative including feeling empowered and valued, while EBO representatives are learning all the time from EBEs who are helping to shape more responsive multi-agency systems. Within the 5 Boroughs Partnership an involvement scheme ensures EBEs receive out-of-pocket expenses, recompense for their time and organisational support.

Outcomes

Within 18 months the project has achieved an ongoing, replicable, cost-effective and comprehensive model of multi-agency working for personality disorder. Key achievements include:

- The establishment of a virtual team of 35 EBOs and eight EBEs working together to develop and deliver the personality disorder multi-agency strategy for Wigan. The team continues...
to expand and new EBEs have recently been recruited to support the ongoing development of the strategy in year 3;
» A high uptake by multi-agencies, which indicates the need and demand for such strategies;
» The development of a sustainable and self-sufficient model of delivering the Knowledge and Understanding Framework basic awareness training, developed by the Institute of Mental Health to support people to work more effectively with personality disorder. This training includes three days of workshops and a virtual-learning environment/distant-learning modules;
» A total of 240 free multi-agency training places being made available in year 1;
» Staff feeling more confident about working with people who display strong emotions or challenging behaviours, and having increased knowledge, confidence and understanding of personality disorder. This has been indicated in evaluations undertaken before and after training;
» Publication of an article raising the awareness of borderline personality disorder and self-injury, which included EBE narratives replicating the strategy’s model of partnership working (Lamph, 2011).

Benefits of the strategy
Our EBE representatives are central to the benefits being recognised. Those who have experience of services are now informing providers what needs to change and are empowered to improve knowledge and understanding of personality disorder among staff in the wider multi-agency system. Many report personal benefits.

Thanks to support from the strategy lead, two user-led organisations have been able to expand to become partner agencies: No Secrets, a user-led self-injury group, provides weekly support groups and professional training; Steps Beyond is an emotional support group providing a drop-in service for people being discharged from psychotherapy, in collaboration with 5 Boroughs Partnership Trust’s psychological therapies service.

Partner-agency services are now taking notice of personality disorder, and it is being discussed in a positive and constructive manner. Their staff are being educated via the sustainable and nationally recognised Knowledge and Understanding Framework programme, and being given the opportunity to work with specialist mental health workers and EBEs on projects that will enable them to respond more effectively to people with personality disorder.

Costs
The employment of a full-time nurse leader is the only essential cost to implement the strategy. A small non-recurrent budget to pay venue overheads and training resources is beneficial if implementing Knowledge and Understanding Framework training, but self-developed in-house training can also be considered. A small budget would also support the creation of projects linked to the strategy, such as providing user-led organisation set-up costs.

Implications for nursing practice
As many partner agencies have significant nurse workforces, a nurse-led project can break down barriers between agencies. People with personality disorder will regularly present to nurses outside secondary mental health services, so increased awareness and improved ways of working with personality disorder among all nurses is vital. The strategy’s proactive approach has enabled partner agencies to make more appropriate referrals to mental health services, freeing them to support those who do not engage with mental health services or who present with less complex needs.

This strategy also provides clarity on care pathways for those with personality disorder across a range of multi-agency services. Breakdown in pathways can be openly discussed, barriers overcome and resolutions created via regular forum meetings. Collaboration across multi-agency services is an exciting and new way of working. Recruiting link EBOs across the organisations, and in particular a dedicated strategy lead who can join up mental health service provision with that of the multi-agency provision, has transformed care for people with personality disorder in Wigan.

Conclusion
This article provides an overview of a unique multi-agency personality disorder strategy. It outlines some of the fundamental factors required for successful implementation and describes the benefits that can be realised; Box 1 shows key elements necessary for replicating our strategy. This low-cost solution to joining wider services proves that a replicable model of comprehensive multi-agency working is achievable.

The design of this strategy could be applied in other areas, such as older people’s mental health or generalised mental health. The strategy and fundamental approach would remain the same but with a different focus and partner agencies. Further research into the cost effectiveness and exploration of reduced transitions through the tiers would be beneficial now the strategy has become firmly established and operational.

References