

# **How to work with teenagers presenting with emerging Borderline Personality Disorder:**

## **Lessons from HYPE**

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“To improve is to change; to be perfect is to change often.”  
Winston Churchill



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## Executive Summary

Borderline Personality Disorder (BPD) is a severe mental disorder that first presents in adolescence or young adults. It is common, occurring in over 20% of the clinical population of adolescents and young adults (Huang, 2009, Chanen, 2004 & 2008). It is associated with significant functional impairment and a high suicide rate of up to 10% (Paris, 2003). It is also associated with other mental health problems, a high burden of care on families and carers, and a high resource utilisation with high treatment costs.

It remains a controversial diagnosis in adolescents although much research now challenges this and there are clinically effective treatments from which young people with BPD can benefit. Classification systems now recognise adolescent BPD, as do national treatment guidelines including NICE which suggest BPD should be screened for, or at least considered early, in the assessment and appropriate treatment offered both to the individual as well as their family or carers.

In the UK we have not yet developed clear assessment routes and treatment pathways for young people with emerging BPD consistently across the NHS. At a time of scrutiny of mental health services especially CAMHS we need to ensure that this risky and complex group are included in service reconfigurations and developments.

Orygen Youth Health and HYPE (Helping Young People Early) offer effective, evidence based and youth focussed interventions to young people. HYPE specifically has demonstrated over a significant period of time that assessing and diagnosing BPD in youth is possible and not harmful. They have shown that treatment can be effective in terms of reducing symptomatology and so potentially reduce the longer-term negative outcomes associated with BPD.

They have also demonstrated that when intervention is aimed at a group with sub-syndromal BPD symptoms they also engage with and benefit from intervention. Indicated prevention is therefore effective and worthwhile as well as early treatment. This potentially offers hope to those with a complex and difficult mental health disorder whose needs should be considered in service provision given their significant difficulties.

HYPE has developed an effective and acceptable intervention for families and carers of people with BPD. These families are often forgotten and struggle to access any support when dealing with very distressing situations with little information about what to do or who to talk to. These families and carers needs also need to be considered as their ability to help and support young people with BPD is extremely important in that individual's recovery.

Research outcomes for young people with BPD have tended to focus on symptomatic recovery, which whilst important, does not equate to functional recovery. Treatment or service developments need to bear this in mind and focus more on what young people view as recovery in terms of goals.

Whilst specialist treatments can be highly effective and valued by young people their development must be balanced against the risk of developing exclusive pathways with rigid boundaries. The risk of this is that young people fall through gaps in service provision and receive nothing or only limited input. They also potentially have only limited choices in terms of what is on offer to them ending up in a one size fits all system.

Services need to be set up and designed with the wider system in mind in order to ensure that different models of care or formulation do not conflict. This should enable young people to manage boundaries and experience transitions across services in as seamless a way as possible.

**Recommendations:**

1. Assessment and treatment for BPD should be embedded within mental health services for young people in the UK. These should include early assessment for traits of BPD and diagnosis if appropriate and then the ability to offer evidence based interventions.
2. Such services should focus on psychosocial and functional outcomes as well as symptoms in BPD. They should work collaboratively with young people to determine what they wish to achieve through treatment.
3. Such services should include support and psychoeducation for families and carers of young people with BPD.
4. The development of specialist provision for specific groups of young people needs to be balanced against the risk of designing a rigid one size fits all system within which young people fall through gaps or get passed around between services.
5. All services working with young people should focus on outcomes and evaluation to ensure that they are delivering effective and acceptable treatments. Services should also start to incorporate research into everyday practice.

## Why me?

I am a Consultant Child and Adolescent Psychiatrist and work in Norfolk, UK, for the Norfolk and Suffolk Foundation NHS Trust (NSFT). I qualified as a Child and Adolescent Psychiatrist in 2005 and have worked mainly within the community but also set up and ran an inpatient adolescent unit in Norfolk for several years.

After completing my training I became more aware of how difficult it could be for young people to access services. Often they have to tell their story many times in order to reach the right person. They are turned away or told they have to wait for too long before they can see anyone. If they get through to a service, they can often only be seen at certain times or in certain places with limited if any choice about this. In addition those young people with ongoing mental health problems approaching 18 and so in need of an adult mental health service often could not access it as they did not meet the criteria set out. If they did manage to get accepted they often did not attend as they did not feel the service was appropriate for them.

I was lucky enough to be given a 'Collaboration for Leadership in Applied Health Research and Care' (CLAHRC) Fellowship in 2012 in the East of England. This allowed me, alongside a colleague, to look at service provision in Norfolk for young people with mental health problems between 14 and 25 years old. The evidence from this emphasized the 'cliff edge' at 18 when our services received the greatest number of referrals but had the least amount of clinical contact. It also showed how complex the system of provision across many agencies in Norfolk was for young people to navigate.

These issues and our CLAHRC findings led to a movement in Norfolk about 5 years ago to radically change how we deliver services to young people and the development of our Youth services (Wilson, 2017). This is now a service aimed at people under 26 years old presenting with complex mental health problems and offers a range of treatments focusing on the needs of a youth population. Many of our aims and principles were influenced by those of Orygen Youth Health as an international center of excellence in youth mental health.

As we reconfigured services and focused on those with the most severe or complex issues it became apparent that a significant number of young people had difficulties or symptoms consistent with an emerging Borderline Personality Disorder. Whilst we tried to develop clear clinical pathways and interventions for this group of young people, we did not have consistent ways of approaching either diagnosing or treating these young people which led to my interest in trying to understand more about it. My hope is that we can start to talk about how to develop services for these individuals in the UK.



## Aims and objectives

I applied for a Fellowship from the Winston Churchill Memorial Trust with the aim of visiting ORYGEN Youth Health and spending time with the HYPE team in Melbourne.

In CAMHS we are in an exciting time in terms of developing services and prioritising what the NHS can deliver in the UK. The government and media have focused on mental health services and specifically CAMHS recently producing various taskforce and reports. One particular area they have highlighted is crisis or urgent provision for young people especially out of normal working hours.

Young people with features of an emerging Borderline Personality Disorder frequently present in crisis and often this is out of hours. Their needs are not always readily met in a CAMHS service in the UK that remains reluctant to assess for and diagnose these problems and does not have well described treatment strategies or care pathways for them.

I wanted to get an in depth understanding of how a specialist team (HYPE) work with these young people and their families. How they assess them and what they offer to them in terms of treatment both in hours and out of hours in order to start to think about developing services in Norfolk (and the wider NHS) for this specific group in the UK.

Whilst it is possible to get a sense of how a service works from their publications this can depend on what or how they present things and it is difficult to get a really comprehensive picture without spending time with them as they are working. I aimed to meet members of the team, to sit in on their clinical sessions and talk to their clients and their families. I hoped to learn what worked well and what was more problematic in terms of how HYPE worked, in order to think about what would work on transfer to a UK NHS setting.

In addition I hoped to get an understanding of how HYPE fitted within the Orygen Youth Health set of services, and how this in turn worked alongside other services within North West Melbourne for clients and their families. Again, I hoped to understand what worked well from their very specialised teams or pathways and what may cause more issues or problems for patients either accessing treatment or moving between services.

I also wanted to get a sense of where they felt they needed to be looking to in the future, particularly in terms of their next developments and any future evaluations or research.

## Introduction

### Child and Adolescent Mental Health Services (CAMHS)

Mental Health services including CAMHS in the UK has been increasingly in the spotlight over the last few years. This has led to a call for parity of esteem across the NHS in order to ensure that mental health gets equal recognition with physical health.

In terms of CAMHS, a cross party group set up a taskforce in September 2014 (The Children and Young people's Mental health and Well-being Taskforce), which produced a report (Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing). This outlined a broad set of recommendations, which they felt would facilitate greater access and standards for CAMHS services. Their aspirations for future CAMHS services included:

1. Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people, where there is less fear and where stigma and discrimination are tackled.
2. In every part of the country, children and young people having timely access to clinically effective mental health support when they need it.
3. A step change in how care is delivered, moving away from a system defined in terms of the services organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families.
4. Increased use of evidence-based treatments with services rigorously focused on outcomes.
5. Making mental health support more visible and easily accessible for children and young people.
6. Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.
7. Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.
8. A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.
9. Improved transparency and accountability across the whole system, to drive further improvements in outcomes.
10. Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.

Following this the government agreed to allocate some increased funding to CAMHS and asked every area to develop Local Transformation Plans (LTP's) which described how they were doing currently and then asked what they would like to transform to improve systems. They asked areas to particularly focus on key issues raised by Future in Mind including:

1. Promoting resilience, prevention and early intervention
2. Improving access to effective support – a system without tiers
3. Care for the most vulnerable



4. Accountability and transparency
5. Developing the workforce

More recently the Government have produced their Five Year Forward View for Mental Health ([www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce/FYFV-final.pdf](http://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce/FYFV-final.pdf)) which again highlights CAMHS focussing on integrating schools into the CAMHS system, funding for CAMHS, vulnerable groups, mental health staff recruitment and retention, and early intervention.

This gives those of us working in CAMHS a fantastic opportunity to think about what we deliver and how we could bring about transformation across our services both generally but also with regard to specific high risk groups of young people such as those with emerging BPD. We need to develop these plans now before this opportunity passes.

### **Borderline Personality Disorder (BPD)**

A Personality Disorder is a pervasive disturbance in an individual's enduring pattern of inner experience and behaviour manifest in several areas. These include how an individual thinks about themselves, others and the world, their emotional experience or expression and their patterns of behaviour (Tyrer, 2014). BPD is one particular type of personality disorder.

Borderline Personality Disorder was first described about 75 years ago and is a debilitating disorder that occurs in approximately 1-3% of the general population. It is characterised by a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts (DSM V, American Psychiatric Association (APA), 2013). Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy.

Individuals with BPD often engage in self-injurious and suicidal behaviour, gambling, compulsive shopping, substance or alcohol use, binge eating and reckless driving (APA, 2000, 2013). Given that these types of impulsive and self-destructive behaviours may lead to psychiatric hospitalisation the rate of BPD in psychiatric settings is even higher (approximately 20%) and in inpatient setting as much as 40% (Chanen, 2004 & 2008).

In addition to high levels of psychopathology this group of patients also have severe psychosocial dysfunction independent of any axis I diagnoses (Chanen, 2007). This means that treating their symptoms of depression for example, whilst helpful, will not mean they achieve recovery or improved psychosocial function. We need also to assess and treat the BPD symptoms to achieve this.

BPD emerges from multiple risk factors and there is no single explanation for its cause. It begins in adolescence and usually remits by middle age. Consistent precursors in childhood have not been identified but there is evidence of particular internalising and externalising symptoms in childhood that appear to precede the development of overt BPD.

Thus BPD is not only prevalent but is also associated with a significant public health concern and this clinical and social burden makes the idea that BPD could be diagnosed and treated early of significant interest.

## **BPD in adolescence**

There is long-standing general consensus that BPD has its roots in childhood and adolescence (as early as DSM-II; APA, 1968) but diagnosing BPD in youth remains controversial.

When surveyed in 2009 the majority of British psychiatrists considered the diagnosis of adolescent Personality Disorder invalid (Griffiths, 2011) and many clinicians remain uncomfortable diagnosing personality disorders in children and adolescents in the UK. This means that young people presenting to services in the UK may be offered sub-optimal or inappropriate treatment as well as not being given an understanding of what is wrong with them.

Explanations for this include the problem of distinguishing the features of BPD from the normal developmental trajectory of adolescence, the idea that identity formation is incomplete in this group, or concerns about stigma. It may also be due to difficulties in distinguishing BPD from other emerging serious mental disorders such as depression and psychotic illness.

Adolescence is associated with a degree of moodiness and impulsivity however these problems rarely reach clinical significance. Similarly some of the behaviours that characterise BPD such as self-harm and substance misuse are often the subject of adolescent experimentation but this usually remits by adulthood. However research does not support the idea that adolescence is a time of troubles with most adolescents managing without experiencing “adolescent turmoil”. Those adolescents that do experience significant or persistent BPD symptoms should not be dismissed, as they are likely to continue having serious symptoms into adulthood (Paris, 2014).

Literature on the stability of normal personality suggests no sudden changes between the second and third decades of life. Studies of personality disorder in clinical and community samples of adults suggest modest stability and, in samples of adolescents, that they have similar patterns of stability to adults. A sample of older adolescents presenting to an outpatient service over 2 years found high stability in terms of personality disorder justifying diagnosis and early intervention (Chanen, 2004).

This suggests that diagnosing BPD in adolescents would have reasonable validity. This pattern of behaviour is likely to remain stable over time and is not likely to be an artefact, nor a feature of either normal adolescence or another mental health condition.

Stigma and the fear of giving a young person a potentially long term and negative label may be valid and BPD can be seen as a particularly pejorative term. It is often negatively thought of among professionals as well as among patients and their families or carers.

This stigma can affect how practitioners respond to individuals, sometimes through distancing themselves from these patients. This can inadvertently contribute to the patient's self-injury and early withdrawal from treatment by exacerbating their own sense of unworthiness and rejection. This can therefore clearly affect the experience the patient has from help seeking and the treatment they then receive (Aviram, 2006, Yasgur, 2015).

Patients own experiences of trying to access care following a diagnosis of BPD can often be negative and involve significant discrimination. A recent survey of Australians with BPD revealed that discrimination was common especially when seeking hospital admission during crises and that these individuals were left waiting in emergency departments for significantly longer than general patients (Lawn, 2015).

There are many stories on the internet written by young people with regard to their experiences of having a diagnosis of BPD and accessing treatment ('Rebecca', 'Seaneen', 'Anonymous A', and on YouTube including Sierra Venegas, Emma Taylor) highlighting how confusing and mixed this experience can be (see links to these in the reference section).

This stigma can also affect the families or carers of patients with BPD. In a similar survey of Australian families they found that these families experience a range of barriers when attempting to get support and these families appear to be largely invisible, experiencing a lack of recognition and support (Lawn, 2015).

Whilst the concern about stigma is genuine, and the response to avoid using the label is well intentioned, this avoidance, rather than honest engagement, risks perpetuating the negative stereotypes and so the stigma associated with a diagnosis of BPD. It also reduces the prospect of applying beneficial interventions and education for the problems associated with BPD and so challenge the hopeless or negative perception associated with it.

Those adolescents that have BPD have high levels of impairment and although the symptoms do attenuate over time this does not mean they achieve recovery as much of the functional disability seems to remain. In fact a BPD diagnosis defines a group with the highest levels of psychopathology and the most severe psychosocial dysfunction, predicting further mental health diagnoses as well as other problems including interpersonal problems, distress and overall reduced quality of life (Chanen, (2009). This highlights the need to establish and offer timely, acceptable and effective interventions.

With regards to treatment there are effective interventions for adults with BPD but there is less research on adolescent interventions. However there are several studies with interventions aimed at young people suggesting that treatment can be effective.

There are 2 programmes developed as early intervention, which target subsyndromal and syndromal BPD. These are Emotion Regulation Training (ERT) (Schuppert, 2012) and Helping Young People Early (HYPE) (Chanen & McCutcheon, 2009). In addition there are studies looking at other therapeutic interventions adapted for use with adolescents with BPD, which include Dialectical Behaviour Therapy (DBT) (MacPherson, 2013), Mentalisation-Based treatment for adolescents (MBT-A) (Rousow and Fonagy, 2012) and Transference-focussed psychotherapy (TFP) (Clarkin, 2001). Results from these interventions appear relatively promising although there are methodological limitations and more research is needed.

There are now various guidelines on the treatment of BPD (NICE, 2009, NHMRC, 2013), which conclude that BPD is a legitimate problem, including in young people, and deserves care and resource. They suggest that diagnosis needs to be done appropriately and carefully and should include early detection and intervention as part of routine clinical practice. They

also conclude that treatment should be primarily psychological, reserving medication for co-occurring problems or co-morbidity, not for primary treatment of BPD.

In conclusion BPD can be assessed for and diagnosed in young people and there are evidence-based treatments for it. It is time that we in the UK started to put this into practice in accordance with national guidelines. We need to capitalise on the current time of transformation and service redesign within CAMHS in the NHS and use this to advocate for services for this group of high-risk patients and so start to see that their needs are met.

### **Helping Young People Early (HYPE)**

HYPE was set up in 2000 by Andrew Chanen and Louise McCutcheon as part of Orygen Youth Health in Melbourne to provide indicated prevention and early intervention for BPD. The goal of the service is to offer optimal effective treatment as early as possible in the course of BPD and to ensure that this intervention is appropriate to the phase of the disorder and the developmental phase of the individual and his or her family (Chanen & McCutcheon, 2009).

HYPE referrals have to meet the general Orygen Youth Health entry criteria and then have 3 or more of the DSM-IV-TR BPD criteria. These criteria are:

1. Frantic efforts to avoid abandonment
2. A pattern of unstable and intense interpersonal relationships
3. Identity disturbance
4. Impulsivity in at least 2 areas that are potentially self-damaging
5. Recurrent suicidal behaviour
6. Affective instability
7. Chronic feelings of emptiness
8. Inappropriate intense anger
9. Transient stress-related paranoid ideation or severe dissociation

The lower threshold than that required for a diagnosis of BPD (which is 5 or more of the criteria in DSM-V) used by HYPE reflects their aim to mix indicated prevention and early intervention as well as avoiding disputes about eligibility for the service when there is a clear clinical need for intervention. These symptoms must have been present for 2 years and to exist in the absence of mental state disorders such as depression.

HYPE has no specific exclusion criteria and patients are not compelled to attend although the team endeavour to ensure that individuals are making informed decisions to not attend. This 'informed refusal' takes into account that young people with BPD struggle to access treatment because of the very nature of BPD and non-attendance or other non communication is not taken as refusal of treatment. HYPE places a strong emphasis on engagement and outreach aiming to inform patients about the actual nature of the treatment program and the risks and benefits of participating or not.

HYPE use an initial screening instrument, which is the 15 BPD item tool taken from the Structured Clinical Interview for DSM-IV Axis II disorders Personality Questionnaire (SCID-II-PQ). Individuals scoring 11 (which suggests the individual has at least 3 Borderline Personality Disorder Features) or more then receive a detailed assessment including a

timeline to try and distinguish state- vs. trait-based problems. This is important in terms of being confident that the young person receives the correct diagnosis and then an appropriate and effective intervention.

Cognitive Analytical Therapy (CAT) is the core of the HYPE therapeutic model. CAT is a time limited, integrative psychotherapy developed in the UK over the last 30 years or so. It is practical and collaborative in style with a particular focus on understanding the individuals' relationship patterns and the thoughts, feelings and behavioural responses that result from these patterns (Ryle, 1997a).

HYPE clients are offered up to 16 sessions of individual CAT with 4 post-therapy follow up sessions to monitor progress and risk. This is somewhat shorter than traditional CAT, which is often up to 24 sessions, recognising that young people engage better with time limited interventions.

HYPE also recognise that, for young people with BPD, endings or transitions in relationships can be particularly difficult. They therefore try to ensure this is done effectively rather than the young person dropping out of treatment prematurely. Their aim is that the young person has the experience of a positive ending with the team and so will bring this forward if it looks like they will not manage to complete all 16 sessions in order to achieve this.

The HYPE model is an integrated team-based model with several key elements (Chanen & McCutcheon, 2009):

- Rigorous diagnosis of BPD and other personality pathology
- Individual CAT
- Assertive case management integrated with the delivery of psychotherapy
- Active engagement of families or caregivers, with psych education and sessions of family intervention
- General psychiatric care, with specific assessment and treatment of co-occurring psychiatric syndromes, including the use of pharmacotherapy when indicated
- Crisis team and inpatient care, with a clear model of brief goal-directed inpatient care
- Individual and group supervision of staff
- A quality assurance programme

HYPE aim to intervene early in the course of BPD and so reduce poor outcomes before they become entrenched and to promote healthier development. Specifically this would be through improving young people's function and reducing their symptoms so they can lead healthier lives.

HYPE also aims to reduce or prevent harmful treatment and consequent iatrogenic harm and to promote adaptive help seeking strategies. This is important in helping reduce their subsequent contact with mental health services if at all possible or if not possible helping these individuals to manage future contact in a positive way. Many individuals with BPD have had very negative experiences of help seeking and can develop negative strategies for

future help seeking as a result, which only results in further harm. Clearly any way we have of reducing this will help both the individuals in question but also services in the future.

Since starting out HYPE has endeavoured to evaluate how effective its programme is for young people with BPD and have produced data with regard to this. Overall they conclude that early diagnosis and assessment is crucial and that psychosocial treatment is effective for adolescents with BPD features as well as the full syndrome. However they also conclude on looking at the various RCTs done that structured or manualized treatment as usual is also effective and the additional therapeutic intervention(s) do not seem to add significantly. In addition whilst research can demonstrate a reduction in the clients symptoms it does not necessarily improve their level of psychosocial functioning.

This is important as it demonstrates that early diagnosis and treatment is possible and effective but that we need to increase our focus on psychosocial function as well as symptoms. It also suggests, that whilst HYPE is effective, alternatives offering a structured package to young people with BPD may also be effective and possibly more efficient in terms of cost and benefit when thinking about transferring this to a UK setting in the NHS.

Recently Professor Chanen and colleagues have proposed the idea of stepped or staged care for BPD. This would start with initial diagnosis and assessment. Those with sub-threshold features would receive enhanced primary care treatment (given the likely prevalence) and then those with first presentation would receive secondary and tertiary care depending on complexity along the lines of HYPE and finally the most severe and multiple presentations would receive Dialectical Behavioural Therapy (DBT).

## Itinerary

I travelled to Melbourne in October 2016 and arranged to spend 4 weeks based with Orygen Youth Health (OYH) at their Parkville site, which is where the HYPE team are largely based.

As part of my visit I had meetings arranged with various clinicians in the HYPE team as well as Professor Chanen and Louise McCutcheon. I had also arranged to meet with each of the other teams within Orygen Youth Health, which include their Early Intervention and Prevention Centre (EPPIC) service, Personal Assessment and Crisis Evaluation (PACE) and the Youth Mood Clinic as well as their inpatient unit and the Youth Access team.

In addition I arranged to meet with some of the senior leadership team at OYH and the HYPE research lead.

Whilst in Melbourne I also arranged to visit the local adolescent unit, Banksia, which is in the Royal Melbourne Children's Hospital and following this to visit one of the local CAMHS clinics.

## Orygen Youth Health (OYH)

### **The beginning:**

Professor Pat McGorry set OYH up in 1988. Its purpose was to provide early intervention for young people with a first episode of psychosis recognising that psychosis starts before adulthood or 18 years old. This began as a small research unit and developed into what is now called the Early Intervention and Prevention Centre (EPPIC) who work with young people with psychotic disorders facilitating early identification and treatment with the aim of reducing the disruption to the young person's functioning and psychosocial development.

This then developed into a service for a broader group of young people with 'at risk' mental states or symptoms now known as the Personal Assessment and Crisis Evaluation (PACE) team. They aim to work with young people at risk of developing psychosis by identifying them and providing treatment as appropriate in the hope that their early symptoms will be reduced.

About 15 years ago in 2000 Professor Andrew Chanen and Louise McCutcheon started HYPE for those with emerging Borderline Personality Disorder and finally the Youth Mood Clinic was added.

The OYH model focuses on the need for evidence-based mental health services designed for the unique needs of youth. They have developed a set of key guiding principles, which include client-centred early intervention, youth and family participation, clinical staging and evidence-based practice.

In addition to developing clinical services for this group of young people they recognised the importance of embedding research into services in order to evaluate things right from the outset. OYH was set up with Melbourne University at the start and they have remained very much part of how things develop ever since. Research workers sit alongside clinicians in all the clinical streams enabling clinical work and research to work in partnership.

Both EPPIC and PACE were internationally ground breaking and were recognised as leading the way in helping young people particularly those with psychotic symptoms. This led the way to our own Early Intervention in Psychosis teams in the NHS. The OYH model has been emulated in many countries around the world including the US, UK, Canada, Europe, Hong Kong and Singapore.

HYPE has added to this reputation and is now an award winning service in its own right offering early intervention and indicated prevention for young people with Borderline Personality Disorder.

### **OYH now:**

OYH provide what we in the UK would think of as secondary care mental health services for young people aged 14 to 25 inclusive in North West Melbourne. This region covers a population of about 1.75 million people and is a diverse area covering the northern and western suburbs of Melbourne as well as its central business district. Its population is growing rapidly and is forecast to reach 2 million by 2020.



OYH receive about 4000 referrals per annum, which go into their Youth Access Team (YAT) who then triage each one. Referrals mostly come from primary care or other health providers but they also accept self-referrals where appropriate.

They initially screen each one to ensure that the individual meets their eligibility criteria in terms of age and being registered in North West Melbourne. They then screen to ensure that they meet eligibility for one of the OYH clinical programs. In general a referral to OYH is considered eligible if the individual has had persistent issues for a period of time, if this has affected many aspects of their life and their safety, and if the young person has not responded to treatment already provided elsewhere.

They do exclude young people who have received extensive treatment elsewhere as their primary focus is on early intervention. For example if a young person has been on an antipsychotic for 6 months or more or spent a significant period of time in hospital they would refer onto an adult mental health service rather than being taken on by OYH.

OYH divide their services into Acute Services, Continuing Care Teams and Psychosocial Recovery.

- Acute Services include YAT (who as well as triaging referrals also do a lot of the assessments and provide an out of hours crisis service 24/7) and an inpatient unit for 18-25 year olds requiring admission.
- The Continuing Care Teams are EPPIC, PACE, HYPE and the Youth Mood Clinic.
- Psychosocial Recovery includes a group programme that all young people receiving a service from OYH from any clinical stream can access as well as an active youth participation programme, family peer support and vocational services.

Once a referral has been triaged and accepted they are then booked in for an assessment and these total about 1200-1500 per annum. Most of these assessments are done by YAT but if it is clear which Clinical Program the young person is likely to need that team will do the assessment if possible to try and avoid repeat assessments.

The assessment aims to be comprehensive and includes a number of screening tools and more in depth questionnaires. From these OYH take on about 1000 young people for treatment into the clinical streams. These young people are offered a maximum of 2 years intervention from the date of being accepted by OYH. At the end of 2 years they are all either discharged or referred on to alternative provision. All of the clinical streams offer a case manager led intervention and each have a therapeutic model.

Outside of these described clinical streams or programmes OYH do not offer treatment. This means that an individual between 15 and 25 years old with an eating disorder for example would need to find treatment elsewhere. Individuals who have a co-morbid eating disorder with BPD, psychosis or a significant mood problem would be seen within those pathways although none have staff with a specialism in treating eating disorders. Sometimes they co-work such cases with other services such as that provided at the Royal Melbourne Hospital who offer care for Anorexia or the Royal Children's Hospital who also provide some treatment for Eating Disorders.

## **EPPIC & PACE**

OYH remains focussed on picking up **all** young people with a psychotic disorder early. To do this they screen all young people coming through YAT with the PQ16 (Prodromal Questionnaire, Loewy, 2005). If a young person scores 6 or more they are then assessed with the CAARMS (Comprehensive Assessment of At Risk Mental States, Yung, 2005) to assess in more detail the extent of any psychotic phenomena they may be experiencing. The assessment of eligibility is entirely symptom based (frequency, duration and intensity) and neither EPPIC nor PACE exclude individuals on the cause of psychotic symptoms or use formulation to exclude cases.

Both EPPIC and PACE use Cognitive Behavioural Case management developed specifically for early intervention in psychosis or 'at-risk' mental states. This is based on the principles of Cognitive Behavioural Therapy (CBT).

Every client is allocated an Orygen Case Manager (OCM) who provides general care coordination and psychotherapy tailored to their issues. Initially the OCM will focus on engaging the young person and getting to know them, building on their relationship and supporting them to manage any practical issues. The focus will then move onto therapy using CBT.

The goals of their intervention include:

- Monitoring their mental state and any risk
- Psychoeducation with the individual and their family or carers as appropriate
- To minimise the duration of untreated psychosis
- To reduce any trauma or anxiety symptoms
- To facilitate treatment including medication if appropriate
- To reduce the adverse impact of their illness on their level of function
- To foster recovery and optimism.

Intervention is offered for up to 2 years as needed with the primary goal of discharging someone from mental health services.

## **The Youth Mood Clinic (YMC)**

YMC aim to work with young people experiencing depression, bipolar II disorder (non-psychotic bipolar disorder) and severe anxiety disorders such as anxiety and obsessive-compulsive disorder. Those with Bipolar I disorder (psychotic symptoms) would be referred into EPPIC. They also use a screening tool, which is the PHQ 9 (Patient Health Questionnaire, Kroenke, 2001) with a cut off of 14. They also look at an individual's risk and complexity of presentation to determine eligibility for their service.

YMC also offer a CBT based case manager led intervention with a focus on formulation of an individual's problems. They have a multidisciplinary team and can offer other therapy types as well as CBT including Interpersonal Therapy (IPT), Acceptance and Commitment Therapy (ACT) and Cognitive Analytical Therapy (CAT).

They aim to offer a brief (usually 6 month) intervention and young people may receive more than one episode of care over a 2-year period. They aim to discharge people from mental health services with primary care support if necessary.

## OYH Organisational structure

I was interested to meet with a number of the senior leadership team at OYH as many of the difficulties they encounter on a day to day clinical basis seemed very familiar to those we have in the NHS – capacity and demand, gaps between teams, limits on what they are able to offer, communication both internally and externally, recruitment and retention. They had also recently separated most of their teams into 2 geographical hubs and were just about to commence an extensive building project on their main campus, which will mean they have a brand new purpose-built space but clearly some disruption along the way. I hoped they might have some answers that I could take home.

OYH has what seems initially a complicated leadership structure that they call the leadership matrix. This incorporates a clinical stream leadership group covering each program and a regional coordination team, which includes the Inpatient Unit and YAT and the Psychosocial program.

Over both these groups they have an Executive Group who aim to hold things together with each member covering several of the other groups and feeding back.

Director of Clinical Services, Program Manager, Medical Director & Associate Medical Director					
	CCT Region A Coordinator Lead Consultant	CCT Region B Coordinator Lead Consultant	IPU Nurse Manager Lead Consultant	YAT Coordinator Lead Consultant	Psychosocial Recovery Programme Coordinator
<b>EPPIC stream leadership</b> 2 names	2 names	2 names	1 name	1 name	1 name
<b>PACE stream leadership</b> 2 names	2 names	2 names	1 name	1 name	1 name
<b>YMC stream leadership</b> 2 names	2 names	2 names	1 name	1 name	1 name
<b>HYPE stream leadership</b> 2 names	2 names	2 names	1 name	1 name	1 name
Coordinator Community Development					

I was struck by the importance of clinical leadership as everyone involved had a clinical background and had previous roles in OYH and many continue to work clinically either in OYH or in other roles. This seemed fundamental to their ethos and culture at OYH that is always focussed on providing the best expert and evidence based care for young people.

## **HYPE**

### **Assessment:**

As described previously HYPE use the 15-item BPQ to screen for features of Borderline Personality Disorder. A score of 11 or more suggests they are likely to have 3 or more features of BPD as described in DSM-V.

Following this the client then has a comprehensive assessment with a member of the HYPE team, which includes describing the features of BPD in detail and screening for features of Antisocial Personality Disorder. They require the symptoms of BPD to have been present for at least 2 years and to be persistent outside of any other mental state disorder such as depression.

In addition they check for symptoms related to other mental state disorders such as depression, and screens around substance misuse, sexual health and physical health. They also spend time describing a time line with clients to establish that the features of BPD are persistent and outside any episodes of depression or other mental state disorders. They also use an array of clinician-completed measures at baseline.

If a young person has features consistent with psychosis or an 'at-risk' mental state the team will transfer over to the EPPIC or PACE teams as appropriate and will not continue to work with that individual. They aim to do this as early as possible to avoid transferring people between teams once they have built up a relationship with them however if symptoms appear later in their course of treatment they will transfer but will also try to complete their treatment first. This means that a significant number of young people in OYH with features consistent with BPD are treated within EPPIC and PACE and so do not receive specific treatment for BPD. They estimate that this is around 20% of the client group in each of EPPIC and PACE.

### **Treatment:**

Following assessment, which can take several sessions, each individual taken on for treatment by HYPE, is allocated to an Orygen Case Manager (OCM). They try to ensure consistency as far as possible so that the OCM doing the assessment will take that individual on for treatment.

HYPE use Cognitive Analytical Therapy (CAT) (Ryle, 1997) as their therapeutic model so all their Case Managers are trained to deliver CAT. Once they have established a relationship with the client their CAT begins and they offer up to 16 sessions of this closely following the CAT model of reformulation and revision.

Integral to the HYPE model is recognising how difficult endings can be for individuals with BPD and so their treatment model is very much set up to deliver episodic care. This means that they aim to discharge people once they have completed their CAT and they can then return for further top-up sessions if they need to later. It also means that if it looks like a young person is going to leave treatment early they will try to focus on making the ending constructive and do this earlier than session 16 if necessary.

Young people with BPD can be a particularly challenging and chaotic group to try and engage in therapy and many drop out of treatment. In HYPE they estimate that about 30% of clients assessed get some case management but do not start therapy as they leave before commencing and 40% start CAT but do not complete 16 sessions. On average a complete episode of care takes about 8 months and about 30% of the clients they take on manage this. They have noticed that if a client gets to the reformulation stage in CAT (about session 3 or 4) they seem to manage to go on to complete their therapy.

Once they have completed therapy the aim is for the client to be discharged out of mental health services as far as possible. Following the end of treatment they are offered a follow up at about a month and if all is going well at that point they are then discharged. They are also offered 3 further follow up sessions at 2 months, 4 months and 6 months, which are entirely voluntary for the client as they are no longer OYH clients. Sometimes young people will continue to have Case Management sessions after they have finished CAT if they continue to have needs requiring further input.

Following discharge most clients are referred out of mental health services to either their own care or self-management or a GP service (Chanen, 2009) but there are a few that require referral on to adult mental health services. They estimate these being less than 5 a year (out of about 150 cases seen over the year). They rarely refer a client on for further therapeutic input preferring to recommend that they have a break from therapy initially.

Overall HYPE see about 150-180 cases each year and hold a caseload across the team of about 90 cases. They have seen an increase over the last few years but manage this by capping how many cases they take on for new assessments to about 7 a month. Beyond this they will stop taking new referrals unless the risk or complexity is so great there is really no alternative.

#### **Inpatient care:**

Many clients with BPD present with risks around self-harm and suicide and so need intensive support and even admission into hospital. They try to ensure admission is the last option and only done when absolutely necessary, recognising the risks of admission as well as the benefits. They aim to admit only with specific goals developed in collaboration with the client by establishing what the client sees are the benefits of hospital and whether they could achieve this any other way. Then the aim is to have clear outcomes for both the client and the hospital team with clear advice about when they can be discharged. Options prior to admission include increasing the intensity of input with the client, often by sharing this with another HYPE team member and/or accessing additional support from YAT out of hours. HYPE research suggests that only the minority of cases have an admission and the average duration of these is only a couple of days.

#### **Family work:**

As well as offering individual case management and CAT to every client there is an expectation that every OCM will also work with the client's family or carers if the individual is happy for them to do so. This involves helping them understand BPD and so what is happening but also how their roles can impact on this either positively or negatively.

In addition to this within the service they have a dedicated case manager to be the family worker and to offer to see families and carers of young people within the service (with consent). This is primarily to complement what the OCM is already doing with the client's family or carers for the more complex families and can offer them some more therapeutic input along the lines of the CAT model.

As part of this role they have developed a group programme called "Making Sense of BPD" (MSBPD). This group is offered to all families or carers and consists of 3 2-hour sessions with families expected to attend all 3. The aim of the sessions is to help families understand what BPD is and to develop some strategies to help manage it and avoid unhelpful patterns of interaction. The initial session is largely psychoeducation around Personality Disorder and specifically BPD with some information about what helps and what does not. They then go on to look at causes and relational skills to try and help families and carers begin to recognise any unhelpful patterns and try to alter these. The whole thing is compatible with CAT so as to compliment the treatment received by the young people themselves.

They have evaluated the group and are currently doing a further evaluation comparing it to online modules available to families and carers to see if the group is more effective or not. The previous evaluation showed increased knowledge regarding BPD and a reduction in the participant's subjective sense of burden.

#### **The team:**

The HYPE team is, like all the OYH teams, multidisciplinary. They are primarily Clinical Psychologists or Occupational Therapists, but can also be Mental Health Nurses or other allied health professionals. Their primary concern is that the practitioner qualifies to be able to deliver CAT or start the training to do so.

In addition they have a number of Psychiatrists in the team and all clients taken on by HYPE will be allocated a doctor and meet with them in the early stages of treatment. The purpose of this is to confirm diagnosis and appropriateness for HYPE, to manage any additional issues around risk and to offer medical treatment if appropriate. The doctors are also trained in CAT and will have a small caseload of clients themselves who they see for therapy.

HYPE recognised early on that working with just clients with BPD features can often be stressful and can lead to burn out and sickness or high rates of staff turnover. They therefore do not have anyone within the team full time clinically. Many of them only work part time at OYH or have other roles within the service such as research or leadership.

Each OCM has a caseload of up to 15 cases per whole time equivalent. This is also less than the caseloads within the other OYH clinical streams (22 per whole time equivalent in PACE or YMC and often more in EPPIC as they cannot restrict who they take on as they aim to see everyone with psychosis). This is in part because HYPE is seen as needing to offer an intensive level of support and treatment given the nature of BPD.

In addition the team work very much as a whole. They meet weekly as a whole team and discuss every client open to them (currently 90 cases in 2 hours). They also all have individual supervision fortnightly and weekly group CAT supervision. This is seen as essential

both in terms of staff support and quality assurance for the HYPE model as well as ensuring the treatment delivered retains its focus and progress for the client.

### **HYPE Research/Training**

HYPE has conducted a number of evaluations since its inception in 2000 and currently has a number of projects on-going. These include MOBY, Verbatim, MSBPD and STRESS:

- MOBY aims to compare 3 forms of early intervention in first presentation BPD with people being randomly allocated to one of;
  - HYPE including CAT
  - HYPE without CAT but with a befriending programme
  - Primary care treatment as usual with befriending programmeThey are evaluating social adjustment and interpersonal problems through self-report and quality of life plus substance misuse, self-harm and suicide rated by clinicians who were blinded to which arm of treatment they had received. They have nearly completed collecting follow up data on this and hope to start evaluating it this year.
- VERBATIM aims to compare treatment for BPD with auditory hallucinations: HYPE plus Aripiprazole compared to HYPE plus placebo. They are currently recruiting young people with full BPD (5 criteria or more) and scoring for auditory hallucinations on the CAARMS (Comprehensive Assessment of At Risk Mental States, Yung, 2005), which they need to experience most days in a week. These individuals will then all receive treatment within HYPE but will be randomised to either Aripiprazole or placebo.
- Making Sense of BPD (MSBPD) group from families or carers versus 2 online modules developed for families or carers of HYPE clients. They aim to evaluate this through perceived burden, knowledge of BPD, coping ability and general levels of distress.
- STRESS is looking at stress vulnerability in young people with BPD by using MRI scans of patients doing stressful tasks and evaluating how they do in a stressful situation compared with clinical and healthy controls.

In the future they have a number of research projects they would like to be able to conduct if they are successful with funding applications. These include using Omega 3 supplements in BPD, looking at more functional based treatment such as vocational support in addition to HYPE vs. HYPE alone and further studies involving their family group perhaps comparing it to an on line provision and support.

Unlike the other OYH clinical programs HYPE have not produced a manual although they have produced papers based on what they do. However they run regular training sessions including several Webinars available on the ORYGEN website (<https://www.orygen.org.au/Campus/Expert-Network/Webinars>) as well as regular CAT training.

They have also had ideas and discussions about how to take the HYPE model beyond OYH either to other teams in Australia or internationally and so to evaluate its effectiveness elsewhere.



## Beyond OYH

Much of the work OYH and specifically HYPE do entails working with other organisations and networks. Like the UK, and indeed more so, Australia has many providers of healthcare and many layers to this in what is a complicated structure and is hugely variable across regions.

OYH receive referrals from many sources including GPs and Headspace services. Headspace are openly accessible mental health centres for young people and provide a range of interventions to a youth population. OYH has a centre in the outer suburbs of Melbourne called its Sunshine Campus, which is co-located with a Headspace service and relations with them appeared generally positive. However other Headspace services are run more separately and OYH have to make connections with them. There is also a multiplicity of private providers in Australia all of who potentially refer in to OYH as well as being potential providers of after care if necessary.

In addition given the client group HYPE work with they have to link with inpatient services. This worked well with their own Inpatient Unit, as the staff, on both sides, were familiar with each other and the ethos of how they worked enabling clients to be managed seamlessly across the community and hospital. However for those under 18 requiring admission HYPE had to link with their local adolescent unit, Banksia, in the Royal Children's Hospital.

It was apparent from early conversations with clinicians in HYPE and hearing their on-going case discussions about their most risky teenagers that this relationship was much more strained and clearly had a significant impact on patient care. Both HYPE and the adolescent unit have very different models of care and it appeared difficult to reconcile these or even find ways of talking to them to help manage young people across the divide. Once a young person was admitted to Banksia their care model took over and when they came out they went back to the HYPE model.

To give one example, which happened whilst I was there, the HYPE team were seeing a young girl who they felt was having a first episode of psychosis. They had explained this to her and her family and they were planning on transferring her to EPPIC for treatment of this. However the clinical team in the adolescent unit disagreed and told her and her family that she was not psychotic but was experiencing symptoms as a result of trauma. This clearly led to both her and her family feeling confused about what was actually going on at a time of significant distress and difficulty. This difference of opinion not only did not help her start to recover but also appeared to make what was a difficult situation even worse. The HYPE team tried to join up with Banksia staff but struggled to do so and to find some common ground. Such clinical differences of opinion are also relatively commonplace in the UK and can lead to confusion as illustrated.

HYPE offers training and support to other teams to try and improve communication. They delivered a session to the team at Banksia whilst I was there which was largely well received although key figures were less receptive or did not attend. The ward staff appeared genuinely interested and afterwards were asking advice about a number of patients they were seeing. This seemed a good opportunity to build relationships and start to improve the

co-working however it also needs to involve the senior clinicians on both sides. As I was leaving the HYPE team were planning for their lead Consultant to go and meet with the Consultants at Banksia to take this forward.

I also met with a community based CAMHS Psychiatrist who talked about relationships with OYH and the difficulties this sometimes threw up. Again, he described different models of care with the CAMHS model being focussed on formulation and describing the aetiology of symptoms such as hallucinations compared with OYH who do not do this but treat the symptoms as they are no matter what the origin.

He also talked about the difficulties of finding treatment for young people who do not fit into one of the OYH care streams. He described a 15-year-old boy with an Autistic Spectrum Disorder and other complex developmental issues plus behavioural problems. He did not meet any of the criteria for OYH but neither did he fit anywhere else. This meant that they were left continuing to support him beyond what they were commissioned to do until they found something else although it was highly unlikely they would find anything provided even within the private sector given the complexity of the boy's needs and risks.

## Client and carer feedback

I met a number of patients and their families receiving care or treatment from HYPE who were on the whole extremely positive about the input they had had.

One girl and her mother could not have been more positive about the team and how they had treated her. She was coming to the end of her treatment with HYPE and she and her mother genuinely felt they had saved her life. She talked about the level of insight she had now into her mental health and whilst she was aware she might have problems in the future she felt she would be able to manage them better.

Another young man and his father starting the treatment pathway with HYPE were also very positive about their experiences to date and felt hopeful that with HYPE's input he would recover his sense of wellbeing.

However I also met a patient who was being transferred to EPPIC after a short while with HYPE. She felt she had finally got to the point of trusting someone enough to talk about her psychotic symptoms having hidden these experiences for a while. As a result of taking what felt like a big step for her she was then having to transfer to a new team and learn to trust them which she was not very happy about. In addition, whilst this was happening, she felt her treatment or care plan was in limbo and she was asking for lots of reassurance about what would happen next.

I met another patient who had previously seen HYPE but dropped out after several sessions. She had been admitted to the OYH inpatient unit with concerns about her safety, as she was feeling suicidal. She was reviewed and offered HYPE intervention again. She was not very happy about this as she did not feel it had helped before but also did not feel she had any option as nothing else was available.

It seemed apparent that young people accepted into the HYPE model who managed to engage well and stick with treatment really benefit from it and do better. They appear to feel positive about the diagnosis of BPD and HYPE believe that they have not had anyone react adversely to being told they have BPD since their outset. CAT as a therapeutic model integrated with case management appears to fit for young people and make sense to them.

However, there is also a group of young people who do not engage so well and so drop out of treatment and there is no alternative treatment for them. In addition, there is another group who have to move to alternative streams within OYH as a result of their symptoms who perhaps have a less positive experience overall. And finally, the very complex and high risk group of under 18 year olds who have to go into hospital may also struggle in experiencing different and sometimes incompatible models of care.

Our UK services face similar dilemmas with those that engage being positive but often "voting with their feet" and dropping out of treatment. This can then lead to them falling through gaps in services and inevitably not accessing any appropriate treatment.

## Conclusions:

### OYH

Overall the clinical care offered by OYH in all its clinical streams was impressive. Each stream had a clear sense of focus and purpose including a therapeutic model that they used. Every member of the clinical streams was trained in that therapeutic model and was well versed in using and adhering to it.

However the risk of having such specialist clinical streams is that individuals fall between teams or end up having to move around within services, which we know young people do not like. It also means that there is a level of rigidity in terms of what young people can access with little perceived choice. They have to accept the OYH models of intervention even if they do not feel they are helpful.

It was also apparent that there were significant gaps in what was available. This means that there are a number of clinical groups whose needs were not met at all or were only partially met in the area that OYH cover. These include those with Eating Disorders or Developmental Disorders for example. Some of these individuals were seen within OYH however they did not get specialist treatment for those conditions but were treated within an existing clinical stream for a co-morbid problem.

It was difficult to understand in the complex healthcare system in Australia where young people who do not meet the criteria for OYH either through severity, complexity or clinical presentation do go for help. They do have successful Headspace models that aim to see a broad range of young people with mental health problems within limits of state funding and there is a large private network of a variety of therapeutic interventions but clearly access to these depends on social circumstances.

Our NHS in contrast endeavours to meet the needs of all that require an intervention without excluding or disadvantaging any particular group. This means that we can see a wide group of individuals presenting with a broad range of issues and so potentially exclude less. However given its broad remit it can mean that we do not offer the highly specialised services to particular groups who then may miss out on specific treatments although they will get something.

In the UK we do have some mental health teams with very specific remits such as the Early Intervention in Psychosis teams or teams working with individuals with Eating Disorders. As they work with a clearly defined patient group and have clear goals and purpose it can make it easier for them to work well in a way that is similar to the OYH clinical streams. In generic CAMHS services or even Community Mental Health teams for adult patients in mental health it is much harder to replicate this clarity of purpose and language.

Clearly we need to find a way of balancing both these issues and so being able to meet the needs of all those that need treatment as well as providing specialist evidence-based treatments to specific groups as indicated. It is possible to assess groups of patients and so separate out people who may be presenting in a particular way and then provide something distinct to that specific group if clinically appropriate. In this way it would be possible to

start to develop specific treatments for groups of young people presenting to CAMHS services. This approach might balance the specialist with the broad in that we would be offering something to the many but delineating those groups that need something specialised.

This means finding smart and consistent ways of assessing young people presenting for help and establishing clear guidelines and treatment pathways for particular presentations. These need to be flexible so that young people presenting with a mixed or complex set of needs can be offered something that feels appropriate to them and not turned away on the basis that they do not meet criteria for a specific service or get passed around between teams as their needs change.

## **HYPE**

Visiting HYPE stimulated many thoughts and ideas, which are pertinent to how services may develop in the UK.

HYPE has a clear assessment process allowing them to identify the clinical population that they wish to target with BPD and emerging BPD. They then offer a very specific treatment with clear goals and outcomes, which was designed for this client group, and was therefore well thought out in terms of meeting their needs. This included focussing on interpersonal relationships and therapeutic endings with an episodic model of care recognising the particular issues that BPD can entail. This was also designed in part to avoid any iatrogenic harm caused by developing people's dependence on services and aided by clearly describing the goal of discharge from mental health treatment.

The family work started by HYPE in terms of the MSBPD groups felt an excellent innovation and an important step in terms of progress for families or carers of young people with BPD. This group also have a high level of need, which is often missed in mainstream services. The data they had collected with regard to MSBPD was very positive and it was inspiring to see that this was continuing. It was also an extremely well valued part of what they offer by the team itself and they were keen to ensure the maximum numbers of families were able to attend this.

The team worked really well together. They all speak the same therapeutic language when discussing cases avoiding interdisciplinary debate or conflict especially with the more complex or high-risk cases. They discuss every case every week meaning that everyone is well aware of what is happening with each and this is recorded. Again, this is particularly helpful in managing the riskier or more complex cases as everyone in the team was aware of the plan and so could step in to support when others were not available.

HYPE have high levels of staff supervision in various forms allowing staff to feel supported and able to discuss concerns they have in a number of ways about their clients. This also ensures that they have high levels of fidelity to the clinical model and can be confident that they are delivering what they say they are.

They encourage staff to develop other skills or interests so as to keep team members from simply doing clinical work recognising that this can be unhealthy in the longer term.

Embedding research within the team and ensuring it is thought about and discussed routinely was also impressive. It appeared genuinely part of their routine practice and allowed them to continue to evaluate and be open minded about their interventions.

Whilst HYPE manage to keep the number of hospital admissions to an impressively low number of clients and for only very short durations to avoid iatrogenic harm, some young people were having multiple admissions over short periods. In addition young people within HYPE who need to access the adolescent unit at times of peak distress and risk struggle across a communication and therapeutic model divide. This felt potentially harmful in terms of their perception of treatment and recovery as communication between the 2 services got in the way.

Overall HYPE demonstrated that it is possible to assess and diagnose BPD in young people and to describe a group with emerging BPD features without causing harm. They also show that it is possible to offer a specific treatment to this group that is both acceptable and effective. Alongside this they have developed an effective family or carer intervention that complemented their treatment and was found to be useful and effective.

In the UK we have begun to recognise that this group of young people present with particularly challenging issues within our system and we need to learn from the HYPE experience and decide what we can imitate within the NHS. We can develop ways of assessing young people routinely for BPD features and then develop treatment pathways for this group within generic services as well as offering information and support to their families and we need to start doing this.

## **Recommendations for UK services:**

### **Borderline Personality Disorder**

1. In the first instance we need to develop services that assess and diagnose BPD to systematically pick up those individuals presenting with early symptoms and those with subsyndromal BPD. This needs to be done carefully and rigorously, taking into consideration concerns about potential stigma, using validated screening and diagnostic tools. By doing this we can begin appropriate treatment as soon as possible and be clear that we are offering this to the right young people.
2. We then need to develop services to ensure that we are systematically offering evidence-based treatment to those with first episode BPD and those potentially developing it (targeted prevention). This needs to include specific interventions (psychoeducation and therapy) for families and carers.
3. These services need to consider incorporating the list of core attributes in their development including (Sharp, 2015, Chanen, 2013):
  - a. Broad inclusion criteria combining indicated prevention with early intervention
  - b. Careful diagnosis, often supported by semi-structured interview(s)
  - c. Extensive efforts to engage and maintain this through assertive outreach
  - d. Time limited intervention which is developmentally appropriate
  - e. Consistent, common, 'plain language' model across all aspects of care
  - f. An explicitly collaborative approach with the patient
  - g. Maintenance of treatment fidelity and quality assurance through supervision of all staff
4. If such services are developed, consideration needs to be given to closely monitoring caseloads for staff given the complexity and potential high levels of risk with this client group. This needs to look at staff morale and potential burnout as well as recruitment and retention.

### **CAMHS/Youth mental health services**

1. Our services need to be clear with regard to what they offer, to whom and for how long. This may improve engagement with young people as well as improve focus on their goals for treatment. These need reviewing and refreshing with young people regularly throughout their treatment to ensure we remain focussed on what they wish to achieve.
2. Services also need to begin to use routine outcome measures and use these to evaluate service quality. By doing this we can aim to continually improve the outcomes achieved and use these measures to judge with our patients where recovery is occurring and if not to review the intervention(s) offered. In addition research needs to be given greater visibility and priority within services.

3. We need to consider balancing “health” or “medical” outcomes with more recovery orientated services which are more in keeping with what young people want to achieve with help and support. This would mean addressing psychosocial and functional outcomes as well as symptom-based measures.
4. Importantly we need to ensure that, whilst specialist services for specific disorders can provide excellent treatment for particular client groups, we do not create a complex system within which young people fall between gaps between teams or do not fit into any specific pathway and so do not receive treatment.
5. Having a core clinical model within a service or clinical team appears to improve efficacy of what services offer as well as improve teamwork and staff morale. However any potential clinical models also need to fit alongside services with potentially different models and avoid difficult transitions for young people moving between services or breakdowns in communication between services.



## Dissemination and Implementation

- I have begun by disseminating my Fellowship findings and recommendations within my organisation (Norfolk and Suffolk Foundation Trust) through presentations to local teams in Norfolk and Suffolk and to our Trust Board.
- I have joined the Trust group looking at services within our organisation for people with Personality Disorders.
- I will aim to disseminate my findings within the Eastern region by presenting to colleagues; for example at the Eastern Region Child Psychiatry Forum in February 2017.
- I have also begun to disseminate my findings more broadly at National conferences for example at a Conference in January 2017 regarding developing Youth Mental Health services in the UK where I was invited to present.
- I have begun to develop and implement a treatment pathway for young people presenting with emerging BPD within my locality together with the Youth team in Great Yarmouth and Waveney. This will involve specific screening measures and individual interventions.
- I have also begun to develop and implement a specific intervention for families or carers of young people with BPD presenting to our service.
- I have made contact with Professor Peter Fonagy and we are developing a research proposal looking at a specific intervention for BPD in schools in the UK. As part of this we have begun to develop an intervention to work alongside school staff with young people presenting with BPD.
- I have made contact with and hope to join our group in Norfolk developing services for BPD to the Global Alliance for Prevention and Early Intervention in BPD (GAP).
- I have linked up with Sarah Amani who was also a Winston Churchill Fellow in the 2016 cohort. Sarah also visited Orygen and we hope to think together about how we might collaborate in terms of disseminating findings.
- I plan to write another blog for our NSFT Blog and the BeGOOD Project ([www.begoodeie.com](http://www.begoodeie.com)) with regard to learning from my Fellowship.

“Attitude is a little thing that makes a big difference”  
Winston Churchill

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The Five Year Forward View for Mental Health, A report from the independent Mental Health Taskforce to the NHS in England, February 2016. <http://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health & NHS England.  
<http://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>

## Blogs

My travel blog <https://allhypedupnet.wordpress.com>

'Rebecca' <http://www.mind.org.uk/information-support/your-stories/having-a-bpd-diagnosis-my-reality/>

'Anonymous A' <http://www.time-to-change.org.uk/blog/institutionalised-discrimination-borderline-personality-disorder>

'Seaneen' <http://www.time-to-change.org.uk/blog/stigma-turned-inward>

Emma Taylor <https://www.youtube.com/watch?v=dgSu81gxgTs>

Sierra Venegas <https://www.youtube.com/watch?v=uOG8zULQqew>