Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
COMPLEX EMOTIONAL NEEDS SERVICE (CENS)

Document Reference	SOP22-013
Version Number	1.2
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Instigated by: **Date Instigated:**	Andrew Sainty, Service Manager April 2022
Date Last Reviewed:	2 February 2024
Date of Next Review:	February 2027
Consultation:	CENS Team MH Division Clinical Leads Consultation Experts by Experience Colleagues Consultation Mental Health Division Practice Network
Ratified and Quality Checked by: **Date Ratified:**	Mental Health Division Practice Network 2 February 2024
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*06.04.2022*	*New SOP – Approved at Mental Health Division Practice Network, 06.04.2022*
1.1	*05.04.2023*	*Amendments to the structure; addition to Key Values of CENs; amends to Reduce iatrogenic harm; addition to Clinical Remit of CENs; Consultation; addition of Wider MDT involvement/interface with CMHTs; Humber DBT; Appendix A Key Values of CENs. Approved at Mental Health Division Practice Network (5 April 2023).*
1.2	*Feb 2024*	*Reviewed. Amendments made to referral process. Approved at Mental Health Division Practice Network (2 February 2024).*

Contents

1. INTRODUCTION

Mission Statement

The Complex Emotional Needs Service (CENS) aims to work *for* people who may experience difficulties consistent with the construct of a 'Personality Disorder' to enable them to develop a life of value to them, conceptualising this presentation as the person's attempted solution to circumstance, rather than the problem itself.

Non-Mission Statement

CENS does not aim to 'do for' or 'do to' others. We are not a service that aims to keep people out of services based on diagnostic constructs, or that considers reduced risk as the sole outcome of importance.

Consideration of Terms Used

CENS is a psychology-led service and therefore does not prioritise (or require) diagnosis as a way of understanding an individual's experience. At the same time, we recognise the system within which our service exists, and that a diagnosis of 'Personality Disorder' (PD) can be a valuable and useful conceptualisation for both clinicians and service-users. For ease of communication throughout this standard operating procedure (SOP) the term 'Complex Emotional Needs' (CEN) is used as shorthand for a collection of difficulties that are consistent with a diagnosis of PD.

A key value of CENS is to be person-centred, considering the needs of the individual person in their own context. As such, in practice we do not consider those that we exist to support as a homogenous group with the same needs as each other.

Nevertheless, for ease of reading, we have chosen to use the term service-user to refer broadly to those who we may work for, whilst acknowledging there will be individual preferences for other terms (e.g. patient, client, expert by experience).

We have chosen within this document to utilise the term 'expert by experience' to specifically refer to service-users who provide consultation to CENS and wider organisation to bring the service-user perspective to service delivery and development.

The processes and procedures outlined later in this document are underpinned by:

- Values that CENS clinicians hold (section 7).
- National guidelines and recommendations (section 8).

2. SCOPE

This Standard Operating Procedure (SOP) describes the functioning of the Complex Emotional Needs Service (CENS), which is the Mental Health Division's dedicated focus provision for adults who meet the diagnostic criteria for a 'Personality Disorder'. This SOP outlines how the team will manage referrals for consultation, joint working, and direct intervention.

3. DUTIES & RESPONSIBILITIES

The Board of Directors

The Board of Directors is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to NHS organisations. This includes the development of systems and processes for clinical risk assessment and management.

Chief Executive
The Board of Directors delegates to the chief executive the overall responsibility for ensuring the trust employs a comprehensive strategy to support the management of risk, including clinical risks associated with patient care.

Service Managers/Clinical Leads/Matrons
Service managers, clinical leads, and matrons are responsible for:

- Familiarising themselves with the scope of this policy
- The dissemination of this policy to their staff
- Identifying the training needs of their staff in relation to this policy
- Releasing staff to attend for training

All Clinical Staff
All staff who work with patients should have a basic understanding of where they would access further support/supervision for working with service users with 'Complex Emotional Needs'.

All staff working with patients should familiarise themselves with the scope of this policy.

4. STRUCTURE

The Complex Emotional Needs Service is part of the Mental Health Division (planned care), and includes a number of discrete functions:

- Consultation
- Care Co-ordination
- Dialectical Behaviour Therapy (DBT)
- Family Connections Programme
- Knowledge and Understanding Framework (KUF) Training

There is a lead clinician allocated to each area, details can be found on the CENS intranet page (tbc).

The team staffing comprises:

- Service Lead (Consultant Clinical Psychologist)
- Clinical Psychologists
- Advanced Practitioners (any registered profession)
- Support Time & Recovery (STR) worker
- Training Facilitators – Expert by Experience
- Administrative support

Operational management functions are fulfilled by the service manager, and delegated others.

5. CONTACT DETAILS

Complex Emotional Needs Service (CENS) 77
Beverley Road
Hull
HU3 1XR
Telephone: 01482 689156 Email:
hnf-tr.CENS@nhs.net

6. HOURS OF OPERATION

The service will operate Monday to Friday, 09.00-17.00.

The DBT Team will provide some telephone coaching outside of this hours with a specified remit, as outlined in the DBT SOP.

7. KEY VALUES OF CENS

The following outlines the key values that drive practice in CENS, further information can be found in Appendix A.

Relationships are a crucial element of effective support – recognising the importance of therapeutic relationships, we will promote thinking about that relationship (and potential barriers, for all parties), and minimise transitions in care.

Care should be person-focused not protocol-driven – consultation and care is based on a formulation of presenting difficulties.

Reduce stigma

Empowering others – both colleagues, and service-users. Reduce iatrogenic harm

CENS commits to considering its own role in causing inadvertent harm to service-users and strives to avoid this. For example, CENS aims to avoid unfocused support that could be experienced as 'failing' by service-users, to support the system to consider its responses and take short-term risks when risk averse behaviour may cause longer-term harm, and support clinicians and service-users early in their service journey.

8. NATIONAL GUIDELINES AND RECOMMENDATIONS

The CENS processes and procedures outlined below are influenced by a range of publications and ideas from a variety of sources, including:

- Bolton W, Lovell K, Morgan L & Wood H (2014) Meeting the Challenge, Making a Difference. Department of Health.
- Crawford M, Rutter D, Price K, Weaver T, Josson M, Tyrer P et al (2007) Learning the lessons: A multi-method evaluation of dedicated community- based services for people with personality disorder. London: National Co- ordinating Centre for NHS Service Delivery and Organisation. Available at: http://www.netscc.ac.uk/hsdr/files/project/ SDO_FR_08-1404-083_V01.pdf
- Department of Health (2009) Recognising complexity: Commissioning guidance for personality disorder services.
- Lamb N, Sibbald S & Stirzacker A (2018) "Shining lights in dark corners of people's lives" The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder. Available at: https://www.mind.org.uk/media/21163353/consensus-statement-final.pdf
- National Institute for Mental Health in England (2003) Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. Department of Health.

- NICE (2009) Clinical Guidelines CG78: Borderline personality disorder: recognition and management.
- NIMHE (2003) Breaking the Cycle of Rejection: The Personality Disorders Capabilities Framework. Department of Health.
- Royal College of Psychiatrists (2020) PS01/20: Services for people diagnosable with personality disorder. Available at https://www.rcpsych.ac.uk/docs/default-source/improvingcare/better-mh- policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2 (accessed 5 June 2020)
- Sweeney, A., Clement, S., Filson, B. & Kennedy, A. (2016) 'Trauma-informed mental healthcare in the UK: What is it and how can we further its development?' Mental Health Review Journal 21(3), 174-192.
- Slade et al. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry* 13: 1, 12-20

9. CLINICAL REMIT OF CENS

In accordance with national best practice guidance (e.g. RCP, 2020), service users should be supported to access mainstream (generic) mental health services where possible, e.g. Community Mental Health Teams (CMHTs). Additionally, CENS prioritise minimising transitions in care where possible/appropriate (to promote continuity in relationships, active problem solving, and unnecessary disruptions in relationships with care providers), as well as ensuring that service users who present with high levels of risk to themselves or others are not waiting for care. As such, CENS do not operate a waiting list.

In the first instance, CENS will work to support the existing care team (where there is one allocated) to plan and deliver care, and support systems to adapt provisions and consider appropriate referrals. Typically, this will be via consultation from a qualified CENS clinician into professionals meetings, CPA meetings, and/or with individual clinicians, though may include a direct assessment with a Clinical Psychologist (or delegated other with appropriate skills/training) [see 'consultation'].

CENS will provide a *time limited* care coordination function to a small number of clients who:

- Present with needs that are consistent with a diagnosis of a 'personality disorder'

  AND
- Where there are formulated needs that might be addressed by a more intensive, psychologically informed, and/or flexible approach to care coordination (and/or the attempted solutions available within/implemented by the existing care teams are contributing to iatrogenic harm).

Decisions regarding the transfer of care coordination will be a two stage process - via discussion in a professionals meeting/CPA with a qualified clinician from CENS and the existing care team, and subsequent discussion in the CENS weekly multi-disciplinary team meeting.

CENS provides a DBT service, and takes an active role in considering additional therapies with an evidence base for those with CEN. CENS also aim to support the systems around those with CEN, by providing carer support, a Family Connections programme, and providing teaching and training to staff.

9.1. Consultation

CENS aim to empower clinicians to deliver high quality care for service users who may be diagnosable with a 'personality disorder', limiting transitions in care where possible/appropriate, and prioritising consultation to the system, rather than acting on behalf of the system. In line with the Mental Health Division's MDT Care Planning: Good Practice Guidelines, CENS will be available to input into the care planning for any client (regardless of diagnosis), via attendance at meetings, 1:1 consultations, or supervision.

Consultation from CENS will be offered by a qualified clinician from within the team, and will typically involve attendance at professionals meetings or CPAs, and direct discussions with those leading on existing care plans, this may include ongoing supervision arrangements. Initial consultation from CENS will be with a member of the Clinical Psychology team, however ongoing consultation/supervision provision may be offered with any clinician with appropriate skills and experience.

CENS offer consultation (across an extended period of time if appropriate) and supervision to all Humber Teaching NHS Foundation Trust services; CENS also offer time limited consultation (typically one-off, and maximum of three sessions, per clinical issue) to statutory partner agencies (e.g. police, local authority, probation).
This will typically be via attendance at professionals' meetings. Additional consultation arrangements may be brokered with third-sector partner agencies, which would be negotiated in collaboration with senior managers (typically the Mental Health Division Clinical Lead and/or General Manager).

To support the objectives of the CMHT Transformation Programme, CENS take a role in supporting transitions for young people from Child and Adolescent Mental Health Services (CAMHS) into adult mental health services. The role of CENS in these transitions is to (where requested) arrange and chair an optional meeting between relevant professionals from CAMHS and partner agencies, and adult mental health services, to consider appropriate care options. Further information can be found in the CAMHS Transition policy.

CENS are able to offer, in a small number of cases, direct assessments with a Clinical Psychologist (or delegated other with appropriate training, e.g. trainee clinical psychologists, therapists of other modalities). The function of this provision is to provide a psychological formulation, and provide recommendations for ongoing care. This option is available where a member of the CENS psychology team and the existing care team agree that a specialist assessment (i.e. with a psychologist with further training in this clinical area) would be beneficial in determining care pathways – where the existing care team have a psychology provision in situ, it is expected that they are included in consideration of the most appropriate clinician/team to fulfil this function.

Referrals to CENS are for initial indirect input and must be made via the online referral form which is be available on the Trust internet and intranet pages. Referrals will be reviewed on Monday mornings and Wednesday afternoons by the CENS psychology provision and uploaded to the electronic patient record by the CENS clinician with outcome included. CENS will endeavour to attend pre-existing meetings that others are requesting CENS attendance at, though we may not be able to facilitate this depending on capacity and the degree of advance notice. In such cases, we will offer to arrange a consultation for a different time.

The exception to the above process is for Avondale Clinical Decisions Unit, where due to the time-limited model, CENS input at CPA or discharge meetings may be desired at short notice to support effective delivery of the model. In such cases, Avondale may send CPA review invites directly to the CENS email address (hnf-tr.CENS@nhs.net).

CENS will endeavour to attend however where this is not possible we will offer an alternative time. If this is no longer required (e.g. because the patient has been discharged), CENS would be available to provide indirect support to the remaining services in the patient's care (e.g. CMHT), dependent on the submission of the referral form as outlined above; CENS would not contact the other services, the responsibility for them requesting consultation would rest with those other services. If Avondale require CENS input for anything other than CPA reviews, then the referral form must be completed.

Following review of received indirect input referrals, a CENS clinician will contact the referrer via email. Once this response has been sent, we will consider there to be no further action required from CENS if no further correspondence is received. Where there is a delay between a referrer responding to CENS' initial contact, CENS may request resubmission of the initial referral form with updated information; this would be determined on a case-by-case basis and not requested by default, but would typically be requested if 8 weeks or greater has elapsed.

In the rare event there is insufficient psychology staffing available for the referral meeting to occur, referrals would be deferred for discussion to the next planned referral meeting. This should be no longer than seven days after the referral meeting at which the referral should initially have been discussed.

Where specific routine forums exist for clinical discussion (e.g. inpatient/CENS interface meeting), the referral form is not required unless additional ongoing input is being requested subsequent to the initial discussion in that forum.

9.2. Care Co-ordination

As described above, direct referrals for care co-ordination will not be accepted and CENS will not hold a waiting list for care co-ordination. Where there is a consensus that care co-ordination is likely to be beneficial, and there is no capacity to allocate a clinician to this role, CENS commit to provide an ongoing consultation/supervisory role, with regular reviews agreed.

Where care co-ordination is offered by CENS (further to a discussion within a professionals meeting/CPA *and* with agreement from the CENS MDT), it will delivered within the ethos and (time limited) structure below.

The care co-ordination within CENS is formulation driven and person centred, rather than protocol driven, and strives to be holistic/systemic in approach. The primary aim of CENS is not expressly to minimise use of inpatient/crisis care or eradicate risk, but instead to encourage proactive problem solving (including in relation to risk), to promote short term positive risk taking in the service of longer term therapeutic gain, and to develop emotion regulation/distress tolerance strategies, roles/identity, opportunities for meaningful activity/occupation, and robust social support. Reduced risk over the longer term is a likely outcome, rather than the primary goal.

It is recognised that ending relationships with services can often be difficult for most, especially those with histories of disrupted or dysfunctional attachments. CENS provide a time limited intervention to mitigate *some* of the challenges associated with endings (i.e. that the ending be planned, not chosen by the clinician based on potentially subjective factors).

To prioritise a focus on proactive care and therapeutic gain, input will be structured as follows:

STAGE ONE [up to 3 months] – ASSESSMENT

The remit of the initial period is to assess need and determine appropriate parties to deliver a holistic care plan. With the aim of being able to focus on assessing need, rather than responding to potential crisis related presentations, CENS will not hold care co-ordination/case management responsibility during the assessment stage, in relation to responding to unplanned contact – any such need will be met by the CMHT/Locality Mental Health Team duty system where applicable, or the Mental Health Crisis Intervention Team (MHCIT). CENS will act in a consultation and liaison capacity where required.

Assess and identify issues related to:	Complete (or ensure completion by relevant clinician):
• Housing • Finances • Occupation & education • Social and family relationships • Social care needs • Physical health needs • Medication management • Safeguarding • Substance use • Forensic risk	• FACE • Cluster • Proposed care plan • Psychological formulation (either via direct assessment with a psychological practitioner, or indirect formulation where there have been previous assessments/reports) • Proposed, collaborative risk management plan • Health Improvement Profile (HIP) • Make contact with family/carer where appropriate

The clinician should arrange to present to colleagues in CENS as near to eight weeks after commencement of assessment. By 3 months (maximum), it is expected that the clinician will:

- Have identified above issues
- Have presented a collaboratively developed formulation and proposed care plan to CENS, and where applicable to the existing care team
- Have arranged for the formal allocation of a care co-ordinator/named worker within CENS (typically this will be the assessor) *or* have prepared a formal report detailing the rationale for no further direct input from CENS

STAGE TWO [to commence on completion of assessment and not exceed six months in duration] – STABILISATION AND ADVOCACY:

Available interventions:
• Motivational interviewing/goal setting • Organisation of the system • Short-term symptom-based interventions (e.g. sleep, coping with voices, panic attacks) • Family Connections • Psychoeducation (including group)

The clinician should present to their colleagues in CENS 12-16 weeks after commencement of stage two, including:

- Review of the formulation
- Review of the care plan
- Discussion about, and agreement on, the stage 3 plan

STAGE THREE [6 months onwards, can commence sooner]

Defined care pathway, this will include a number of structured interventions:

- Transition to unplanned care where there is no identified intervention need/no commitment to intervention. A care plan will be developed to support unplanned care contact, and a clear outline of recommendations in relation to accessing services in the future, will be developed

OR

- Ongoing care co-ordination with 3 monthly reviews of care plan with the team, focused on 'stage one' issues utilising the principles of Structured Clinical Management (problem solving approach). Optional short-term psychological intervention, including:
  low intensity symptom-based interventions, CBT, CENS psychology, family interventions, Peer Support worker/Support Time and Recovery worker

OR

- Formal (external to CENS) therapy referral (e.g. Dialectical Behaviour Therapy, Mentalisation Based Therapy, Psychoanalytic psychotherapy, CMHT psychology, Family Therapy, Trauma team, CBT, EMDR, Let's Talk, EWS). Ongoing care co-ordination role will be dependent on the limits set by the therapy provider.

OR

- Out of area placement – subsequent to placement ending, arrange professionals meeting to determine appropriate service (return to stage one/CMHT/transition to unplanned care)

STAGE FOUR – POST DISCHARGE FROM CENS (concurrent to other pathways where appropriate)

All clients will be offered a pre determined number of follow up sessions/telephone calls per year (typically between two and four), which can be utilised in a 'crisis' or 'non-crisis' context. The number of sessions will be agreed within an MDT process. This will typically be offered for two years post discharge, however may be extended/withdrawn with MDT agreement. Ongoing telephone support may also be offered.

A CENS referral on Lorenzo will be opened (and subsequently immediately closed) to facilitate appropriate record keeping for any face to face appointments, and the clinician will take responsibility for making any necessary changes to the FACE assessment and other relevant documentation. A referral will not be reopened for telephone support, however where necessary the FACE and any other documentation will be updated. If follow up/additional input is required subsequent to any further support, the individual will be supported by CENS to self refer to the appropriate provision where possible (onward referrals would be made on the individual's behalf where necessary).

9.3. Wider MDT involvement/interface with CMHTs -

CENS does not employ the full range of disciplines often available within a multidisciplinary team (e.g. Occupational Therapy, Psychiatry/Non Medical Prescribers). Where there is a need for a discipline that is not available within CENS, that input will be provided by the CMT serving the locality in which the service user is based.

Where CENS has a dedicated social worker in post:

If a CENS client is already allocated to a social care member of staff within the CMHT, the work required to be completed will need to be led by the named worker. The Advanced Social Work Practitioner from CENS will be able to provide consultation/co-working opportunities to support the practitioner.

If a CENS client is not allocated to a social care member of staff from the CMHT, the Advanced Social Work Practitioner from CENS will take lead on the case, complete the Adult Social Care Assessment and complete the initial 6 week review . Following the 6 week review, the client will then be allocated to the CMHT with the expectation all further reviews will be completed by them.

If a CENS client lives within the East Riding of Yorkshire Council area, the Advanced Social Work Practitioner will not be able to take lead due to social care arrangements for the ER local authority, however will be able to offer consultation/co-working opportunities to support the practitioner allocated the work.

9.4. Between session contact and interface with 'Unplanned Care'

Those who are care coordinated/case managed by CENS will have care access to their named clinician, and in their absence they will have access to the team via a 'duty' system (accessed by calling the admin team – 01482 689156, or emailing hnf- tr.CENS@nhs.net).

There will be an allocated clinician available daily to respond to urgent requests for support, however this availability will be via telephone/MSTeams only, due to capacity CENS is unable to commit to face to face assessments or contacts. The team's generic inbox will be checked a minimum of twice daily, and a response to an urgent request should be expected within 4 hours.

Some clients with an open referral to CENS may not be open to the team for case management or care co-ordination; the purpose of their referral may be assessment, a specific therapy only (e.g. Structured Clinical Management, Dialectical Behaviour Therapy), or indirect support to other services, for example. In these cases, clients are not able to access unplanned support from the team, including for example (but not limited to) support calls during working hours and additional visits prior to being able to access unplanned care services. In such cases CENS is also not responsible for providing a triage or follow-up function for unplanned care services, for example (but not limited to) providing follow-up to clients or jointly assessing clients who have been seen by unplanned care services. To support clinicians in appropriately signposting clients with an open referral to CENS to the most appropriate services when they present to unplanned care, CENS will use Lorenzo to distinguish clients who can/cannot access the team for unplanned support during working hours. To do this, we will endeavour to:

- Add an alert to the patient record for clients with an open referral to CENS who are unable to access the team for unplanned support or for whom CENS are not responsible for follow-ups after unplanned care presentations/joint assessments due to the nature of the service being provided to them, identifying which services would be responsible for supporting the client if they present in an unplanned way, ordinarily this will be the client's existing CMHT, or unplanned care services.
- Record the open referral to CENS for clients who can access CENS/CENS are responsible to support in an unplanned context, as a 'specific procedure' referral, identifying that they are care co-ordinated or case managed by CENS.

9.5. Family Connections

CENS co-ordinates the provision of Humber Family Connections. This is a group programme to provide psychoeducation, skills development opportunities and peer support to individuals who non-professionally support others presenting with emotion dysregulation, which may or may not have been diagnosed as a 'personality disorder'. Family Connections is accessible to supporters regardless of whether their supportee is receiving mental health services or not. Attendees will not have an open referral to mental health services, nor any associated documentation, and there will be no information shared between supporter and supportee in either direction. Any apparent risk issues during Family Connections will be dealt with by signposting individuals to the appropriate services or clinicians.

Any supporter of someone presenting with emotion dysregulation may self-refer (or be referred) to Family Connections provided they are themselves at least 18 years of age and registered with a GP in the Hull or East Riding CCG areas. The age of their supportee is not an exclusion or inclusion criteria. Referral is via the online referral form which can be found on the provision webpage https://www.humber.nhs.uk/Services/humber-family-connections.htm , or by contacting the team via email (hnf-tr.humberfamilyconnections@nhs.net) or telephone (01482 689156).

All Family Connections facilitators are trained by the National Education Alliance for Borderline Personality Disorder (NEA-BPD) in providing the programme. Facilitators may be clinicians, or supporters who have previously completed the Family Connections programme and subsequently trained as a supporter leader.

Family Connections is free to attendees and may be provided in a range of locations (including online), and within a range of days/times to suit demand, where possible. Where facilitating the Family Connections programme involves working later than 8pm Monday-Friday, or at weekends, facilitators are expected to take the time back as time owing, rather than being paid overtime rates. Facilitators who do not wish to do this are able to decline the opportunity to facilitate a Family Connections group during such times.

9.6. Knowledge and Understanding (KUF) Framework

CENS co-ordinates the provision of KUF training to the Trust and partner organisations. KUF is a three day awareness level training for understanding, and working effectively, with clients with Complex Emotional Needs. KUF is a national programme, delivered in partnership with NHS England.

KUF is co-produced (on a national level) and co-delivered, meaning that it is always delivered by both an expert by profession, and a (paid) expert by experience.

9.7. Humber DBT

The Humber Dialectical Behaviour Therapy (DBT) team is part of the Complex Emotional Needs Service. Referrals should be made directly into the DBT team, a client does not need an open referral to CENS to access DBT. Humber DBT has a dedicated intranet page and Standard Operating Procedure (SOP).

Appendix A – Key Values of CENS:

Relationships are a crucial element of effective support
Relational continuity is considered a key aspect of being able to support individuals with CEN. Whilst evidence-based treatments have an important role to play, it is widely accepted that the therapeutic relationship is often the key determinant of how beneficial a particular intervention is. CENS strive to prioritise the maintenance of existing relationships that can be helpful for service-users, rather than expect service-users to develop new relationships with new clinicians to conform to organisational structures. Attention is also paid to the relationships between clinicians, and importance of safety and trust within the consultation and supervision process. It is recognised that the relationship service-users have with clinicians requires engagement from both sides, rather than an expectation that a service-user 'should' engage in a relationship simply because it is offered. CENS also attempts to take into account the role of relationships, at both an individual and societal level, in the development and maintenance of difficulties in the service-user's life, and offer support to reduce the impact of these or create relational change where it can be beneficial.

Care should be person-focused not protocol-driven
Whilst operating within the limits of secondary care mental health services, CENS commit to approaching problems creatively, drawing on a range of ideas and working for the goals of the service-user, rather than the goals of the system. A key aspect of this is that risk behaviour and other behaviours that systems can find challenging be conceptualised as attempted solutions to the problem, rather than the problem itself. The question for services to ask is, 'why is this person doing what they are doing, and how can we help them with that?'. Consequently, CENS believe support should be formulation-driven, and individuals with CEN should not be denied access to support on the basis of diagnostic labels or other discrete tools such as mental health clustering. When an individual, whether a service-user or clinician, asks for support, there is a recognition that they will often feel more able to approach someone they know and trust for this. CENS believe this should be respected and people should be able to access trusted supporters for a discussion in the first instance, rather than service barriers preventing this.

Reduce stigma
The diagnosis of 'PD', behaviours that are consistent with this construct, and those who are labelled in such a way, remain stigmatised. CENS believes a key aspect of our role is to advocate for individuals with CEN to increase access to support, and to increase empathy for individuals with CEN in all forums through formulation. CENS considers individuals with CEN to be able to contribute to services by virtue of being experts by experience, including through training others.

Empowering others
One way of reducing stigma is to support clinicians to work with individuals with CEN, rather than to transfer care to other services, such as CENS. In order to do this, CENS strives to scaffold others to develop their own skills and confidence, whether that by service-users, or clinicians or other agencies. CENS aims to 'do with' rather than 'do for'. This influences aspects such as indirect working being the first- line support to others, and coproduction of care plans and positive risk taking.

Reduce iatrogenic harm
In the same way that harmful behaviour of service-users can be conceptualised as an attempted solution to a problem, so attempted solutions from mental health services and other agencies can become harmful. CENS commits to considering its own role in causing inadvertent harm to service-users and strives to avoid this. For example, CENS aims to avoid unfocused support that could be experienced as 'failing' by service-users, to support the system to consider its responses and take short-term risks when risk averse behaviour may cause longer-term harm, and support clinicians and service-users early in their service journey to identify an appropriate treatment pathway, inputting into generic mental health services rather than being a separate entity that can only be accessed by being transferred.