Recognising complexity:
Commissioning guidance for personality disorder services

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Foreword

Personality disorder (PD) presents many faces across society. When human development is disrupted or disturbed, the psychological, social and economic consequences can touch every part of the individual's life, with repercussions for families, communities and society in general. Some people may struggle with alienated and chaotic lives, asking little of public services. Others may use a range of services (perhaps for substance misuse, or self-harm or criminality) to little benefit. Recognising and understanding the complex nature of PD, and responding effectively, is a growing concern for public services.

In 2003, the publication of *Personality disorder: No longer a diagnosis of exclusion*[1] provided new impetus for mental health services to address the needs of a challenging but disadvantaged client group.

Since then, we have seen significant advances around the country:

- New community and community forensic services have been successfully established and evaluated.
- In 2005, commissioners and partners developed regional personality disorder capacity plans, providing a strategic framework for future development.
- In 2006, the *Social Exclusion Action Plan*[2] initiated a number of new pilots to test preventative approaches with vulnerable children and young people at risk of developing PD.
- The National Institute for Health and Clinical Excellence (NICE) has recently completed guidelines for borderline personality disorder and antisocial personality disorder.[3]

More recently still, Lord Bradley's inquiry[4] on the diversion of people with mental health problems or learning disabilities away from prison and towards more appropriate services provides further imperatives to improve services for people with PD. The report recommends the development of an interdepartmental strategy (involving the Department of Health, NHS and National Offender Management Service) for the management of all levels of PD.

Within this positive context of change, this guidance aims to use what we have learned to support commissioners and service providers in addressing the needs of local populations with PD. Those populations are diverse, as PD can form part of a complex profile of need across many service user groups and age groups. Effective commissioning depends on recognising this complexity as it considers the needs of vulnerable children at risk, offenders, people with substance misuse problems, women with complex needs, offenders and others.

[1] National Institute for Mental Health in England (NIMHE) (2003a)
[2] Cabinet Office (2006)
[3] NICE (2009a) and (2009b)
[4] Bradley, Rt Hon The Lord Keith (2008)

So, while NHS mental health commissioners have a key role to play, they cannot alone deliver better health and well-being for people with PD. Success also depends on developing effective coalitions and joint approaches, most notably with criminal justice system agencies, but also with drug action teams, children's trusts and local authorities.

Government recognises that many departments and agencies need to work collaboratively to achieve the key priorities and objectives that are embodied in Public Service Agreements. Working together, through local strategic planning or locally agreed co-commissioning arrangements, is a necessary foundation for success.

Improving outcomes for people with PD is challenging – but commissioners, providers of services and practitioners are already demonstrating their commitment to the task. We trust that this guidance will support these endeavours.

Professor Louis Appleby CBE
National Director for Mental Health

Acknowledgement

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Executive summary

People with personality disorder (PD) suffer lives of rejection, anguish and alienation. The effects on society are pervasive, chaotic and expensive and cross many organisations, services and systems.

Recognising complexity: Commissioning guidance for personality disorder services aims to support commissioners to work collaboratively in order to address need and improve outcomes for people with personality disorders.

The guidance is based on learning from the Department of Health National Personality Disorder Programme (in particular learning about best practice from pilot services) and feedback and comments from people who use services.

Who is *Recognising complexity* for?

Recognising complexity is essential reading for commissioners in primary care trusts (PCTs) or specialised commissioning agencies, and is also important for commissioners across the criminal justice system, local authorities and others.

Why is personality disorder important?

Personality disorders are complex and common conditions (affecting between 5% and 13% of people living in the community).[5] People with PD may present with a range of physical, mental health and social problems such as substance misuse, depression and suicide risk, housing problems or long-standing interpersonal problems. Some also commit offences and are periodically imprisoned. A small number present a risk to other people and a few, serious danger. The general impact of PD on individuals, families and society is significant.

Key policies and guidance

Over the past 10 years, the Government has produced a number of policy documents focused specifically on ways of preventing PD and providing appropriate treatment and care for people with PD.

1999	Managing Dangerous People with Severe Personality Disorder (DSPD)
2003	Personality Disorder: No longer a diagnosis of exclusion
2003	Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework
2006	Reaching Out: An action plan on social exclusion
2007	Mental Health Act
2009	The Personality Disorder Knowledge and Understanding Framework
2009	The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system

[5] Coid, J., Yang, M. et al (2006); Moran, P. (2002)

Other policies also relevant to PD include Improving Access to Psychological Therapies (IAPT), improving health in the criminal justice system, women's mental health and reducing reoffending.

Additionally, the National Institute for Health and Clinical Excellence (NICE) has recently completed guidelines for borderline personality disorder and antisocial personality disorder.[6]

These policies and guidelines provide a clear direction of travel for commissioners and service providers in terms of both adapting existing services to take account of PD and developing new ones.

Effective commissioning

Because PD is associated with complex need, many commissioners and agencies will be involved in providing services. While NHS commissioners have particular responsibilities and lead roles, for some groups of people with PD, improved health and well-being can only be delivered through partnerships and coalitions with other agencies.

The role of mainstream mental health services

Dedicated PD services are the most effective but mainstream mental health services also have a vital part to play. For instance, mental health services should:

- provide support to people with PD through long-term therapy programmes in line with NICE guidelines
- have appropriately trained staff at key points in the health, social care and criminal justice systems with recognised roles in relation to PD
- provide access to include and involve people with PD.

Commissioning dedicated PD services

To ensure effective care pathways, it is important to develop provision through a whole-system approach, with comprehensive and co-ordinated services.

It is helpful for commissioners to conceptualise this in tiers of provision as follows.

Commissioning for Tiers 1–3

Tiers 1–3 provide services for people with moderate to severe PD. Successful service design elements may include case management and co-ordination, therapeutic community models, a range of psychological therapies, short-term respite or crisis arrangements, service user participation and a focus on recovery.

Commissioning for Tier 4

Tier 4 services are for people with severe and complex PD whose needs cannot be met by the community services in Tiers 1–3 and who may require residential treatment.

Commissioning for Tier 5

Tier 5 services are for people with severe PD who present significant risk of harm to others. Services are largely commissioned centrally. However, local commissioners need to collaborate with colleagues in Tier 5 services to ensure appropriate step-down arrangements where necessary.

[6] NICE (2009a) and (2009b)

Commissioning for groups with particular needs

Commissioners should consider the specific and distinctive needs of groups such as offenders, children and young people, women with complex needs, black and minority ethnic communities and people with substance misuse problems.

Commissioning for outcomes

Routine baseline and outcome data collection is required to make rational choices about competing priorities. Improved quality of life, better relationships, reduced use of high-support and crisis services, and entry into education and employment are important outcomes to measure.

World Class Commissioning

As the Department of Health's World Class Commissioning initiative makes clear, commissioning has a key part to play in improving quality and standards of care. This means, for example, monitoring the outcomes of the service and ensuring that it meets the needs of local people.

Meeting priorities and targets

The Government has not set any specific targets for the treatment of PD. However, since it is common among many of our most disadvantaged groups who are lifelong users of health, criminal justice and social services, dealing with PD effectively will contribute significantly to meeting a range of health targets.

Innovative approaches can also help local authorities to meet a number of their Public Service Agreement (PSA) outcomes as follows:

PSA 12	Emotional health and well-being of children and young people
PSA 14	Increase the number of children and young people on the path to success
PSA 16	Increase the proportion of socially excluded adults in settled accommodation, employment, education and training
PSA 18	Promote better health and well-being for all
PSA 23	Make communities safer
PSA 25	Reduce the harm caused by alcohol and drugs

1 Introduction

This guidance is based on learning from the National Personality Disorder Programme (in particular, learning about best practice from the 15 pilot PD services) and feedback and comments from people who use services.

The guidance has undergone an equality impact assessment and amendments and additions to the text have been made as recommended.

The assessment questioned the approach adopted in this guidance of distinguishing between men and women with PD.

Historically, much of the research, clinical and policy literature regarding PD has not distinguished between the characteristics and needs of men and women. This is, however, a diverse client group which includes small but significant numbers of men who present a high risk of harm to the public, and managing the risk they present will always be a priority. In this context, unless the distinct needs of women are clearly articulated, there is a risk that they will be overlooked.

2 Using this guidance

Personality difficulties and disorders are complex conditions which affect many groups of people in society and which give rise to wide-ranging problems and needs. This guidance therefore covers a lot of ground and will be of interest to many different commissioners and also to service providers and practitioners.

The guidance is primarily for NHS commissioners and managers, recognising their key responsibilities for improving outcomes for people with PD.

However, it is clear that many other agencies face challenges in meeting the needs of people with PD, and that inter-agency collaboration in commissioning and operating services is essential for success. Therefore, this guidance will also be of interest to and prove helpful for commissioners in the National Offender Management Service (NOMS), local authority social care and housing services, and health and social care services for adolescents and young people.

This guidance is based on extensive learnings about best practice from pilot services and from service users. A comprehensive resource with a detailed account of learning from various sources will be published in autumn 2009.

While this guidance aims to support and inform commissioners, the comprehensive resource should be of interest to commissioners, service providers and practitioners.

Part A:
Setting the context

3 Why personality disorder is important

Most people have a 'good enough' early life to be able to develop a stable understanding of self and others, to cope with the stresses of life, to sustain satisfying relationships with family and friends, and to behave in ways compatible with norms and laws.

We use the term *personality disorder (PD)* to describe the problematic ways of coping with everyday life and dealing with self, others and the world which result from the interplay between genetic and environmental factors and disrupted early development.

Personality disorders are common conditions in our society. Epidemiological estimates suggest that between 5% and 13% of people living in the community have problems that would meet the diagnostic criteria for PD.[7]

Between 30% and 40% of psychiatric out-patients and 40% and 50% of psychiatric in-patients are thought to meet the criteria for PD.[8]

Some 50–78% of prisoners have been found to have PD.[9]

> *'I did not access much of mental health services (they would not let me), but I used up hundreds of thousands of pounds of other budgets such as housing, social services and substance misuse.'*

Personality disorders are complex. People with PD may present with a range of physical, mental health and social problems such as substance misuse, depression and suicide risk, housing problems and long-standing interpersonal problems. Epidemiological studies indicate that 20–50% of people with PD misuse substances and 5–30% of people who attend substance misuse services have a diagnosis of PD.[10]

Some also commit offences and are periodically imprisoned. A small number present a risk to other people and a few, serious danger.

Personality disorders are associated with risk. Risk of suicide and accidental death is high and it is estimated that between 47% and 77% of people who commit suicide have PD.[11]

Suicide rates in prison remain several times higher than for the general population.

Because some people with PD engage in impulsive or dangerous lifestyles, they have a higher risk of unnatural or accidental death.[12] A small sub-group may present a high risk to others due to their violent or sexual offending – these are 'high-harm' clients and meet the criteria for dangerous and severe personality disorder (DSPD).

Underlying personality disorders or difficulties may go unrecognised by agencies, practitioners and commissioners. In mental health services, there has been a persistent belief that PD exists in isolation and separately from mental illness. We need to understand PD as intricately interwoven with mental ill health and complex needs.

[7] Coid, J., Yang, M. et al (2006); Moran, P. (2002)
[8] Casey, P. (2000)
[9] Singleton, N., Meltzer, H. et al (1998)
[10] Linehan, M., Schmidt, H. et al (1999); Nace, E., Davis, C. and Gaspari, J. (1991)
[11] Moran, P. (2002); Alwin, N., Blackburn, R. et al (2006)
[12] Martin, R., Cloninger, C. et al (1985)

People with PD often have a complex range of problems and needs, and they may be involved with a number of different agencies. However, their PD may affect their ability to benefit from services. Without the right kind of help and support, their problems are likely to continue, affecting not only their own well-being but also that of society in general.

Because of the widespread impact on society, PD is everybody's business.

3.1 Addressing the challenge

PD poses a significant challenge to commissioners and service providers. However, recent advances suggest that concerted action and action across agencies can:

> improve an individual's quality of life, reducing suicide risk and destructive behaviours

> help people get back to work and education

> reduce pressure on staff and public sector organisations.

Personality disorders are common characteristics of many high-priority client groups. Recognising and addressing PD can play an important role in achieving government priorities set out in PSAs as follows:

PSA 12	Emotional health and well-being of children and young people
PSA 14	Increase the number of children and young people on the path to success
PSA 16	Increase the proportion of socially excluded adults in settled accommodation, employment, education and training
PSA 18	Promote better health and well-being for all
PSA 23	Make communities safer
PSA 25	Reduce the harm caused by alcohol and drugs

Annex 1 provides details of relevant PSAs and implications for commissioners concerning PD.

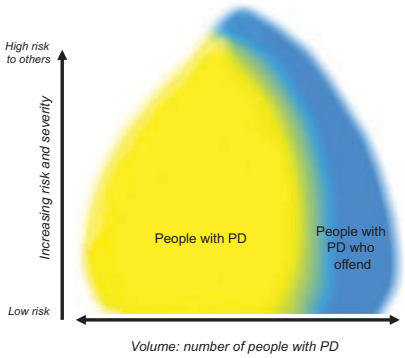
The commissioning task is essentially about recognising, addressing and working with complex needs.

The diagram below outlines features of PD populations showing volume/incidence on the horizontal axis and severity/risk on the vertical axis. It is important to note that:

> these are indistinct, 'fuzzy', overlapping populations

> more people have less serious problems and numbers reduce with increasing severity

> there are small numbers of personality-disordered offenders who present a high risk of harm to others.



4 Key policies and guidance – implications for commissioners

Through a number of key policies, the Government and NICE have set out some clear aims and standards in relation to PD:

> *Managing Dangerous People with Severe Personality Disorder* (1999)[13] sought to remedy the lack of treatment available for those people with severe PD presenting a danger to the public.

> *Personality Disorder: No longer a diagnosis of exclusion* (2003)[14] aimed to remedy the exclusion experienced by people with PD and confirmed that PD services should be part of the core business of mental health trusts.

> *Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework* (2003)[15] sought to improve the capabilities of staff in health and social care in relation to PD.

> *Reaching Out: An action plan on social exclusion* (2007)[16] shifts our focus from managing entrenched problems to prevention, by piloting early intervention services for young people at risk of developing serious PD in adult life.

> **NICE guidelines**[17] on *Borderline personality disorder: Treatment and management* and *Antisocial personality disorder: Treatment, management and prevention* provide a number of key recommendations for the NHS, including:

- spelling out the role of community mental health services and specialist services
- detailing a range of preventative interventions for children and young people at risk of developing antisocial personality disorder (ASPD) and their families
- highlighting the key role of collaborative inter-agency networks in supporting and managing personality-disordered offenders.

> The PD **Knowledge and Understanding Framework**[18] provides a new national education and training package for staff across health, social care and criminal justice, and high-quality education for all staff who come into contact with people with PD.

[13] Department of Health/Home Office (1999)
[14] National Institute for Mental Health in England (2003a)
[15] National Institute for Mental Health in England (2003b)
[16] Cabinet Office (2006)
[17] NICE (2009a) and (2009b)
[18] www.pdinstitute.org.uk

5 The wider policy context and personality disorder

Policy in other areas not primarily focused on PD can affect people with PD, and action to address PD can contribute to achieving these policy objectives.

> The **Mental Health Act 2007**[19] incorporates a significant change in thinking about PD and extends requirements regarding detention, alternatives to detention and appropriate treatments, to people with PD.

> **Improving Access to Psychological Therapies**[20] (IAPT) is a major initiative for people with common mental health problems. It is important that people with PD are identified at an early stage so that they can access the right kind of treatment.

> *Improving Health, Supporting Justice*[21] sets the foundations for developing a national health and social care strategy for offenders.

> The *National Service Framework: Improving services to women offenders*[22] seeks a number of outcomes particularly relevant to women offenders with complex needs and PD, many of whom languish in prison or secure care for want of appropriate services.

> *Women's mental health: Into the mainstream*[23] highlights several areas of significance to women with PD, including initiatives on self-harm and prison in-reach.

> The *National Reducing Reoffending Action Plan*[24] underlines the need for partnership across agencies to tackle the factors that lead to reoffending, and joint action on substance misuse, housing and other key areas.

> *Delivering Race Equality in Mental Health Care*[25] calls for more appropriate and responsive services and applies to PD as well as to other services.

> *Independence, Well-being and Choice*[26] outlines the ambition to transform social care by putting individuals and communities in control of care and support. Local strategic partnerships have a key role in ensuring a balance between prevention and independence and intensive care and support for those with complex needs.

> **The Bradley Report**[27] makes 82 recommendations about the diversion of offenders with mental health problems or learning disabilities away from prison into more appropriate services. There are three recommendations specific to PD, all supported by government:

- an evaluation of treatment options for prisoners with PD, including current therapeutic communities in the prison estate
- an evaluation of the DSPD programme to ensure that it is able to address the level of need
- an interdepartmental strategy – developed by the Department of Health, NOMS and the NHS, in conjunction with other government departments – for the management of all levels of PD within both the health and criminal justice services, reflecting the management of these individuals through custody and then into the community.

[19] Department of Health (2007)
[20] Department of Health (2008)
[21] Department of Health, Department for Children, Schools and Families, Ministry of Justice Youth Justice Board and Home Office (2007)
[22] Ministry of Justice and NOMS (2008)
[23] Department of Health (2002)
[24] Home Office (2004)
[25] Department of Health (2005a)
[26] Department of Health (2005b)
[27] Bradley, Rt Hon The Lord Keith (2009)

Part B:
Effective commissioning

6 Overview

This section provides commissioners with an overview of the key areas that are the foundation for commissioning effective services and systems for PD. Leadership and an ability to create new partnerships across agencies underpin the commissioning agenda and, as would be expected in the commissioning arena, both cost effectiveness and outcomes are considered. In relation to PD, the involvement of service users in commissioning and service provision brings particular benefits as many people with PD have felt disempowered and excluded by services in the past. Finally, reference is made to the quality and skills of staff as, although this is primarily an issue for providers of services, experience of the pilots and best practice has shown that it is an area that could be well supported by effective commissioning in specifying the need for staff to be appropriately trained and supported to work with people with PD.

7 Partnerships, coalitions and leadership

Because PD is associated with complex need, many commissioners and agencies will be involved in providing services.

NHS commissioners have particular responsibilities and lead roles for some groups of people with PD; however, improved health and well-being can only be delivered through partnerships and coalitions with other agencies.

NHS commissioning responsibilities are as follows:

> PCT commissioners are responsible for mental health and prison health services at Tiers 1–3.

> For services at Tier 4, commissioning responsibility varies according to the client sub-group:

- specialised services commissioning for those with high risk of harm to self
- specialised services commissioning with the active involvement of NOMS commissioners for vulnerable women with severe PD
- joint specialised services and NOMS commissioning for the high-harm-to-others group who now need to move into Tier 4.

> Joint specialised services and NOMS commissioning is suggested for the Tier 5, high-harm-to-others group.

World Class Commissioning underpins the crucial role of PCTs leading the health agenda in work with local agencies. Leadership is particularly important in relation to PD because of the involvement of many agencies and because many commissioners and managers have limited understanding of PD and its wide impact.

Commissioners can demonstrate leadership by promoting understanding of PD, encouraging commissioners across a wide range of health services to identify the impact of PD and addressing this where possible.

7.1 Partnerships

Delivering the services needed by people with PD may require some new partnerships to support services that are developing, as well as using existing arrangements more effectively to recognise and address PD.

Integration across health commissioning and collaboration by commissioners for local and specialised mental health services, substance misuse services, child and adolescent mental health services (CAMHS), offender health services and primary care services ensure that PD is effectively addressed in general services for a number of client groups.

Local community partnerships between PCTs, local authorities, local criminal justice agencies and others can ensure that PD is recognised in:

> joint strategic needs assessments

> social inclusion and preventative initiatives

> the development of a range of community accommodation and recovery and rehabilitation services.

Partnership between the NHS and NOMS is essential to deliver services for the larger populations of personality-disordered offenders with less serious problems as well as for the smaller numbers who present a high risk of harm to others. The NHS and NOMS share responsibility for those who present a high risk of harm, and the gradual development of closely aligned commissioning for this client group is recommended.

Personality disorder capacity planning exercises, which were undertaken on a regional basis in 2005, have brought many of the partners together and are an example of collaborative working. Building on experience to date and further development will promote a cross-agency culture and understanding and the development of comprehensive services and pathways.

Local coalitions for *Building Brighter Futures for Children*[28] have resulted in close joint work between PCT commissioners and local authorities working as lead agencies with other partners in children's trusts, which will help:

> early identification and intervention initiatives

> comprehensive CAMHS that address PD

> youth-friendly services for those with emerging PD.

[28] Department for Children, Schools and Families (2007)

8 The cost benefits of effective commissioning

There is an emerging consensus regarding potential cost benefits of effective commissioning of PD services and systems. Some of the areas of cost benefit are drawn from best practice and some from the NICE guidelines on borderline personality disorder (BPD) and antisocial personality disorder (ASPD).

Service level/type	Cost benefit area	Source	Achieved through
Early intervention (children and young people)	Education	NICE guideline ASPD	Reduction in conduct disorder, disruption to education and educational failure
	Social care	NICE guideline ASPD, audit from multi systemic therapy pilot services	Reduction in at-risk proceedings and children taken into care
Tiers 1–3	Primary care	NICE guideline BPD, audit from pilot services	Reduction in attendance
	Medication	NICE guideline BPD, audit from pilot services	Reduction in prescribing costs
	Employment, family disruption, relationship breakdown	NICE guideline ASPD	Reduced costs associated with improvements in all of these
	Drug and alcohol abuse	NICE guideline ASPD, audit from pilot services	Reduction in harm due to use of drugs and alcohol
	A&E	NICE guideline ASPD, audit from pilot services	Reduction in attendance related to self-harm and suicide attempts
	Staff retention	NICE guideline ASPD	Retention increases with proper training
Tier 4	Use of more intensive/ secure services	Evidence from pilot services	Reduced escalation into more intensive/secure services, reduced risk to self or others
	Residential placements for women who self-harm	Evidence from pilot services	Reduced escalation into expensive residential placements, reduction in risk to self
Tier 5	Secure/forensic placements or prison for high-risk individuals	Evidence from pilot services	Reduced escalation into secure/forensic placements or prison, strengthen community management and encourage more rational use of high-cost placements
Tier 1–5	Reduced reoffending	NICE guideline ASPD	Reduction in criminal offences committed (cost of violent crime involving wounding is £19,000 per incident on average

9 Commissioning for outcomes

Using outcomes in commissioning allows commissioners to ensure that provision is well designed and focused, to assess effectiveness and value for money, and to make comparisons across a range of different service models and approaches. Outcomes can be used when commissioning both dedicated PD services and mainstream provision.

Currently, we do not have a body of research clearly indicating which interventions and service models effectively deliver positive outcomes for PD. However, the NICE guidelines and a growing body of best practice experience and evaluations help us to distinguish what is most promising.

Most importantly, there is a growing consensus from clinicians and service users around the outcomes that services and commissioners should be aiming for, whatever the interventions used.

The diagram in section 9.3 suggests a set of outcomes derived from the review processes of the pilot services, reflecting feedback from service users and informed by evaluation studies. These are intended to apply to services for adults with moderate to severe PD and adult personality-disordered offenders with moderate to severe problems.

The outcomes are structured to reflect stages in the pathway that the service user follows from initial contact through treatment and into recovery.

We learned from the pilots that some practice features are essential if services are to effectively deliver positive outcomes – these are incorporated as process outcomes. Information and measurement regarding these variables is helpful for commissioning and probably essential for new or developing services.

> *'I've been with the mental health services for several years. Since my teens, I have received several diagnoses. I found that nothing could help and that I was a burden beyond help.*
>
> *'Although the assessment process here was long and often painful, it was useful as it enabled me to feel safe and fully understood.*
>
> *'Individual therapy has provided a space for me to finally explore and be truthful about the issues, whereas group therapy has provided an environment for validation and an area to experiment in implementing change in a safe environment before the wider world.'*

9.1 Process outcomes

Some key process outcomes are noted in the first box on the diagram.

> **Recognition**
> Unless personality disorders are recognised and addressed, successful outcomes are unlikely. Where offenders have complex needs, including serious mental illness, or where there are no dedicated PD services, PD may not be recognised during assessment or reflected in treatment plans.

> **Case management**
Case management is as important as therapeutic interventions and of itself can have a positive effect on individuals and systems. It holds clients through the care pathway and maintains relationships with other agencies and services. Feedback from service users is that 'feeling safe' is an important part of the treatment process.

> **Pathway planning**
Pathway planning is important for more specialised services, particularly secure services for offenders with PD. It needs to be a part of service design, linked to other services through partnerships, and a routine part of assessment and case planning. Where pathways are not appropriately developed, clients get stuck and services are limited in their capacity to achieve recovery outcomes.

> **Community services partnership**
PD services cannot exist in a clinical vacuum and need to establish networks and linkages (such as managed clinical networks) to help clients access the full range of public services they may need. At a local level, this may mean partnerships with housing agencies, for example.

9.2 Outcomes on the pathway to recovery

> **Assessment and engagement**
Engagement is key to success. People with PD may be suspicious, mistrustful and difficult to engage. Like assertive outreach services, PD services have to develop ways of responding to clients that maximise successful engagement.

> **Mental well-being and pro-social behaviours**
These outcomes reflect the anticipated benefits to service users in relation to the complex problems they face.

Society also has expectations, and reducing offending and risk are key outcomes for personality-disordered offenders.

Feedback from service users shows that improved hopefulness, self-confidence and feeling more in charge gradually increase through engagement and treatment.

Improved mental well-being and stability also reduces the inappropriate use of services, enabling commissioners to use scarce resources effectively.

> **Recovery and longer-term social functioning**
Service users have consistently said that reducing mental ill health through reduced self-harm or crises, for example, is not enough. Getting a life must be part of the goal. For offenders, this means living independently in the community with longer periods out of prison. For all clients it will mean better relationships and continuing progress in managing their lives.

9.3 Using outcomes

Commissioners can use these proposed outcomes to:

> assess, monitor and review the effectiveness and value for money of new and existing services

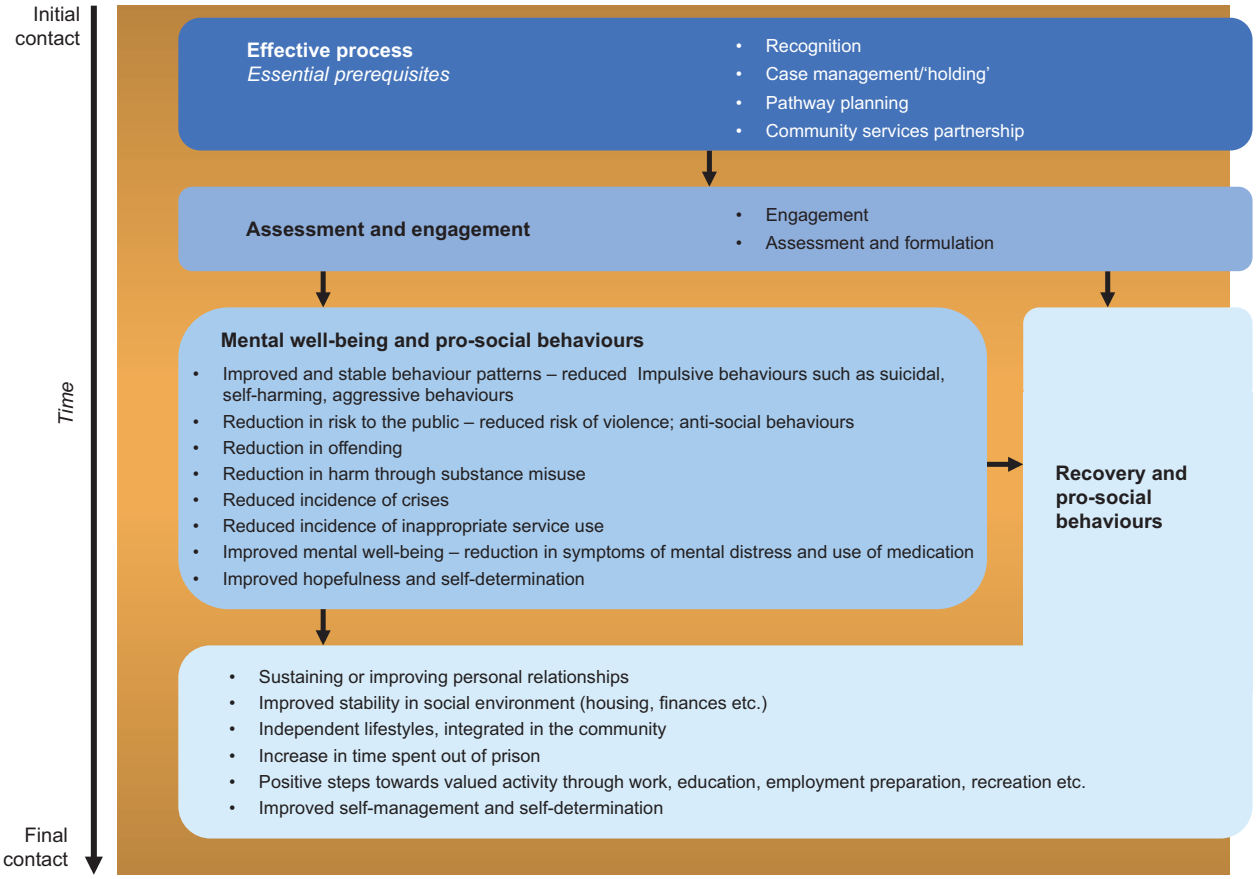
> consider and clarify what outcomes can be delivered by mainstream services as they are currently delivered, or where they may need to be altered or tailored

> ensure the appropriate focus and design of new services

> focus on the establishment of effective process during the development of new services

> ensure that new and existing services address health and social inequalities.

Outcomes on the pathway to recovery



10 World Class Commissioning

Effective commissioning of services for PD relies on the realisation of the vision for World Class Commissioning and application of the competencies. In particular, it is one area in which PCTs can demonstrate strong local leadership and engagement with the full range of stakeholders and local population. PCTs should also be looking to perform a comprehensive needs assessment of their local population for PD services and commission outcome-focused, evidence-based services in line with their strategic priorities.

The World Class Commissioning agenda clarifies that commissioning to improve quality and standards of care relies on:

> using evidence and experience of what works

> identifying the outcomes that services should aim to deliver

> focusing on relevant population groups and need.

In addition to these key processes, some particular features of quality have been highlighted in relation to PD and resources that may support commissioning.

Annex 7 provides detailed advice to PCTs for each of the World Class Commissioning competencies regarding PD.

11 Service user involvement in commissioning

Experience has shown that involving service users in operating and commissioning services is itself a mark of quality, and can have a powerful impact on other aspects of the quality of services.

Policy makes a requirement for PCTs to involve patients and the public. Best practice experience clearly demonstrates that involving PD service users improves:

- self-confidence, self-esteem and self-management
- the overall quality of service provision and delivery.

> *'If you ask whether service users should be involved in policy making, I'd say they should be considered on merit – they need the intellectual capability and to be mentally robust.*
>
> *'Remember that service users haven't always been service users – they had a life before PD. They often feel undervalued and undermined, so why make it worse? Give service users responsibility and they'll show responsibility.'*

A culture which is open to involving service users will be reflected in:

- a focus on therapeutic alliance as the basis for interaction
- practice that develops and promotes self-management and control; for example, through service user management of the Care Programme Approach (CPA) process, and other types of planning and goal setting
- support available in a range of ways to allow for different choices; for example, providing access to alternative therapies and individual as well as group work
- arrangements to ensure that PD service users' views are sought regularly and are part of the decision-making process
- involving PD service users in shaping and operating the day-to-day service; for example, in supporting new clients, developing leaflets and written material, organising day or group activities, and supporting or organising out-of-hours support arrangements
- involving service users in shaping the whole service; for example, through membership of steering committees and boards, in research and evaluation, in recruiting and training new staff and in developing and extending services
- service user views and feedback forming an essential part of the commissioning process
- ex-service users being involved alongside commissioners in needs assessment, development of commissioning plans and service reviews.

12 The quality and skills of staff

The experience of the pilot services and consistent feedback from service users over a number of years make it clear that high-quality staff are particularly important to the quality of services for people with PD.

Commissioners should ensure that:

> recruitment to services for people with PD is alert to the personal attributes, core behavioural skills and attitudes required in successful staff

> procurement processes specify that staff providing services for people with PD are appropriately trained, adequately supported and supervised as individuals and teams

> staff broadly represent the ethnic profile of the communities they work in

> the PD Knowledge and Understanding Framework and training products are effectively used to develop the capacity of the local workforce.

Part C:
Commissioning dedicated personality disorder services

13 Addressing need through co-ordinated systems

Towards a comprehensive spectrum of services for personality disorder

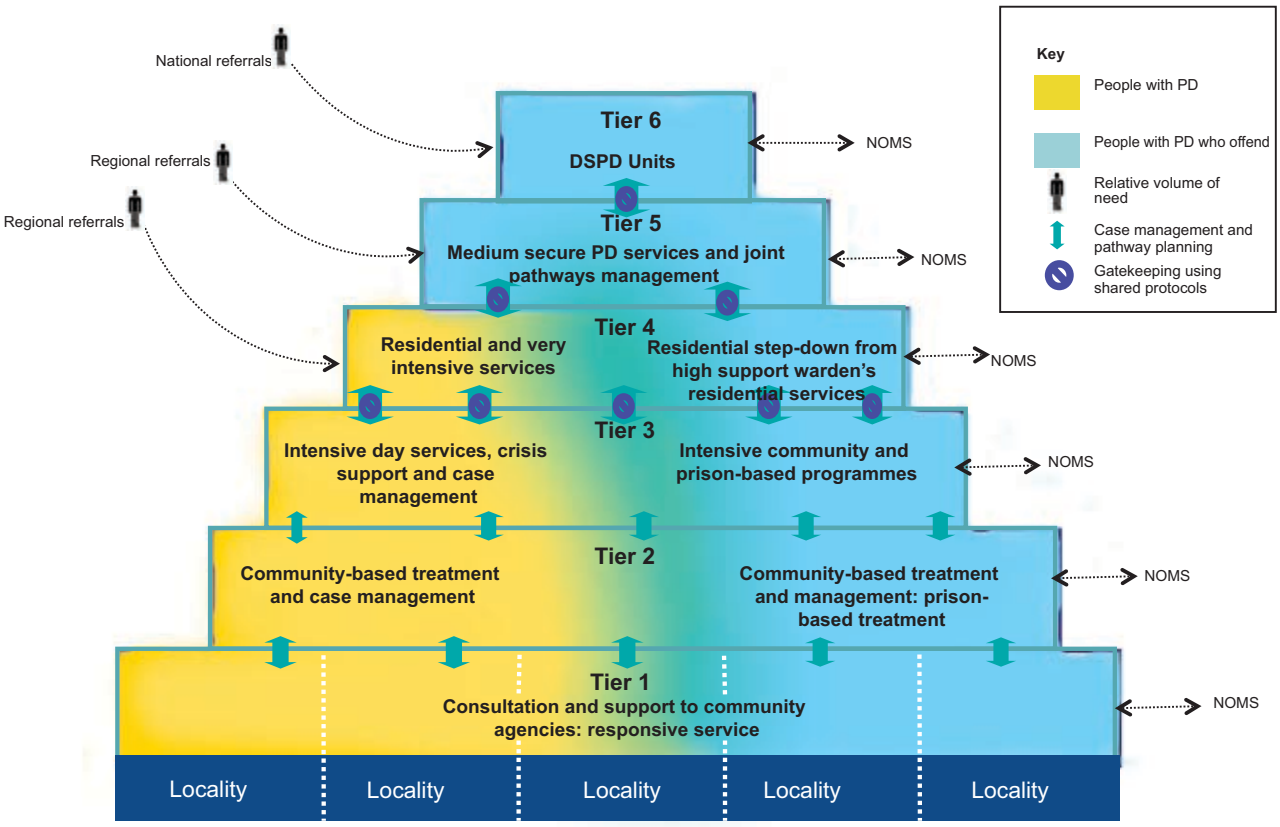
To ensure effective pathways and avoid 'stand-alone' services, it is important to develop provision within an appropriate 'whole system' in order to gradually build a comprehensive and co-ordinated spectrum of services.

The national PD and DSPD programmes, piloting a range of services, have demonstrated how a variety of interventions and service models can be used to address need.

Comprehensive provision also means services that engage and support hard-to-reach population groups, and those with particular needs who may be overlooked. It is important that the development of PD services does not reinforce health and social inequalities.

The tiered model below provides for co-ordinated services responding to different levels and severity of need, with some services available at local level and more specialist responses to severe need provided for wider geographical areas and larger populations.

Dedicated services for personality disorder



The model outlines the comprehensive functions of a PD service system.

> **Tier 1**
> To ensure responsive mainstream services for people with PD. To ensure access to appropriate housing, employment, training etc to support full recovery. Consultation and support from dedicated PD services to community agencies.

> **Tier 2**
To ensure appropriate assessment, treatment and case management in community and prison settings for those who do not pose serious risk to others.

> **Tier 3**
To ensure appropriate assessment, treatment and case management for:

- those whose levels of risk to self and severity require more intensive community-based treatment
- offenders with PD who present limited risk to others.

> **Tier 4**
To ensure appropriate assessment and treatment for diverse population groups with severe and complex PD, who may need to be treated on a 24-hour basis or away from home. These include those who present a high risk of harm to self and some whose risk of harm to others has improved so that they can 'step down' from more intensive and secure services.

> **Tier 5**
To ensure, across health services and the criminal justice system, appropriate assessment and treatment at required levels of security, and longer-term rehabilitation and maintenance/ monitoring for those with severe PD who present a high risk of harm to others. To ensure support to Multi Agency Public Protection Arrangements (MAPPA).

> **Tier 6**
To ensure appropriate assessment and treatment at required levels of security for those with severe PD who present the highest risk to others; and to ensure co-ordinated access to highly specialist facilities in the NHS and NOMS.

It is difficult to be specific about the population catchment appropriate to different tiers of provision. Clearly characteristics such as rural or urban environments, deprivation and known psychiatric morbidity will have an influence. However, pilot services provide a rough guide to numbers, shown in the table below.

Tier	Population catchment
1–3	300,000–1,000,000
4	Small but diverse groups of people with severe and complex PD. As this is low volume specialist provision we recommend that catchment group populations form the basis for needs assessment and commissioning.
5	1,000,000–3,000,000

14 Identifying levels of severity

Ensuring a comprehensive spectrum of services and effective pathways requires the ability to distinguish levels of severity in PD. There is no academic or clinical consensus about defining or measuring severity in PD. However, as a practical aid to service planning, broad assumptions about severity, criteria for assessment and required services can be made, and should inform commissioners, managers and practitioners to support commissioning. Annex 2 suggests criteria to distinguish:

- children and young people at risk of developing PD or with emerging PD
- people with less serious PD
- people with moderate to severe PD
- people with severe and complex PD
- people with severe PD who present high risk of harm to others
- people with severe PD who present the highest risk of harm to others (DSPD).

15 Taking a mainstream approach

Dedicated PD services alone will not be able to meet need and, as NICE Guideline 78 emphasises, community mental health services have an important role to play. Commissioners may wish to use a mixture of specialist and mainstream mental health services to treat and support people with PD. Commissioners and trusts should ensure that mainstream mental health services:

> have inclusive eligibility criteria that really include people with PD

> have information systems that can identify and track people with PD where appropriate (such as high-harm offenders)

> have systems in place to ensure effective assessment and case management for severe/risky PD cases

> provide skilled case management/co-ordination for people with PD (through CPA or other arrangements)

> provide appropriate, accessible, engaging, longer-term psychological treatment programmes for people with moderate to severe PD

> provide effective assessment and gatekeeping for therapeutic treatments, for other intensive care packages and out-of-area placements

> have sufficient skilled staff with recognised roles relating to PD at key points within community and forensic mental health services

> have skilled staff available in both forensic and community mental health services for consultation and support to other agencies in relation to people with PD.

16 Developing a long-term strategic approach

Using the tools and guidance detailed in previous sections should help commissioners to clarify what services are available for people with PD locally and what improvements and developments are needed at PCT, strategic health authority or catchment group/regional level.

The delivery of a sustainable set of processes and structures will impact positively in terms of outcomes for people with PD, and this joined-up strategic approach is more likely to deliver economic and health benefits.

The PD capacity planning process provides a framework within which all the necessary partners can collaborate in strategic planning, needs assessment and review. Moving towards a comprehensive spectrum of services is a significant challenge which may take many years to achieve and requires a long-term strategic commissioning approach.

> *'Before coming to the TC [therapeutic community] I had difficulty with going anywhere by myself. I could not go shopping, walk into town or be anywhere unfamiliar alone. I would panic and feel people were looking at me. I relied a lot on my parents and partner at the time to help me with tasks. I also self-harmed when things became overwhelming.*
>
> *'I had lost my confidence when I came to the TC due to a bad depressive episode in which I was hospitalised. Coming to the TC regularly over the past 16 months has helped me get my confidence back.*
>
> *'I take care of myself now. I have gained my motivation back and attend exercise classes weekly as I became overweight during my depression. My self-harm also decreased.*
>
> *'I have felt the TC beneficial in understanding my personality disorder. It has been a challenging place to work through my difficulties. I have been able to listen and learn through other service users' experiences.'*

17 Commissioning for Tiers 1–3

17.1 Services for people with moderate to severe personality disorder – Tiers 1–3

There are 11 dedicated PD pilot community services around the country which have focused on Tiers 1–3 for the non-offending population, and which have provided significant learning about effective service models.

While the approaches vary the services commonly:

> operate with community teams providing case management and co-ordination/CPA, outreach and community follow-up

> use a variety of psychological therapies including Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Cognitive Analytical Therapy (CAT), group analytical approaches and therapeutic community (TC) models

> provide long-term interventions and support

> provide a range of services across Tiers 1–3 including: support and training for other agencies and services in relation to PD; advice, information and less intensive individual interventions; and more intensive interventions/therapies, crisis support etc for those with more serious problems.

While we do not have high-quality evidence of delivering outcomes, data collection, service user feedback and some audit material indicate that such services can deliver:

> significant benefits for clients (reduction in mental distress; reduced suicide risk, reduced self-harm; improved self-management and self-confidence; and improved lifestyles and recovery)

> significant benefits for service systems and commissioners (reduced inappropriate service use, particularly in-patient psychiatric care; improved capacity in voluntary sector and mental health services for dealing with people with PD).

It is difficult to generalise about optimum capacity and likely costs for Tier 1–3 services. Also local issues may affect design, capacity and costs – for example, where the service covers a wide geographical area, operating at several locations and staff travel time can reduce capacity and raise costs.

However, it is possible to provide a rough guide to population catchments and service costs, as shown in the table below.

Approximate population catchments	Optimum service/client capacity (and other indirect services)	Approximate cost range (£000 p.a. at 2005/06 prices)
300,000–1,000,000	70–120	500–900

The learning from evaluation and from developing best practice in these services indicates key features of practice and service delivery. Annex 3 outlines key practice features.

17.2 Key service delivery features

To be effective, services should be delivered in a way which is:

> **Engaging**
People with PD are mistrustful of services and engagement is key to getting people into treatment and preventing drop-out.

- **Flexible and responsive**
  Including both lower and higher intensity interventions tailored to individual need.
- **Supported by case management/CPA**
  Case management is as important as therapeutic interventions and in itself has a positive impact on individuals and systems.
- **Inclusive of peer group support**
  Clients report that learning from peers is important. Peers can be involved in running some parts of the service such as group work, activities or out-of-hours support.
- **Clearly thought through and articulated**
- **Fully understood by staff**
  Particularly the implications for their own roles and practice.
- **Respectful to clients**
  Able to understand and respect issues relating to race, gender, age, disability, religion and sexual orientation.

While the community-based pilot services initially focused on the non-offending population, some have become more flexible in response to local need. Community-based PD services should be accessible to personality-disordered offenders where possible and appropriate. This might include personality-disordered offenders with less serious problems who do not present risk to others, or those who may have undergone treatment and/or where risk is limited and manageable.

'Before I started getting help from the personality disorder unit I was a complete and utter mess. I knew that I wasn't normal and had many problems. I felt overwhelming despair every waking minute. I hated myself so much that I didn't care whether I lived or died. I was on the road to complete destruction and I was selfish enough not to give a thought to my two beautiful boys. I was going to leave them heartbroken and without their loving mum all because I couldn't cope with my life.

'I was soon diagnosed as having a personality disorder after many suicide attempts. With this diagnosis people's attitudes towards me changed. I was treated in an appalling manner like I was some sort of crazed lunatic. This reinforced my self-hate. I felt that I was right to think as badly of myself as everyone else did.

'With the help of the unit I started to accept that my inappropriate behaviour was attributed to the fact that I was sexually, physically and emotionally abused all my life.

*'It has taken me two years of intense and distressing CBT to get where I am now. Although I still struggle to cope with life and living, I have started to see a glimmer of light in all my darkness. I have begun to understand myself more and I have realised that I can take control back. I have a long way to go yet but the love I feel for my boys is what drives me to change the past and with all the help from the unit I **will** do my best to give myself and my boys the decent future that we deserve.*

'Thank you for helping me to save my life.'

18 Commissioning for Tier 4

18.1 Services for people with severe and complex personality disorder

While a significant proportion of people with severe PD can be treated and supported by local community services, there are a number of small sub-groups who need more intensive provision. These population groups are more diverse than previously thought and not all would historically have been seen as clients for specialist PD services. There is a risk that the needs of these people with severe and complex PD will go unrecognised and unmet.

Therefore commissioners and trusts should:

> ensure that people with severe and complex PD are identified and assessed and do not fall through the net

> carry out needs assessments on the diverse Tier 4 population

> ensure access to a range of services.

18.2 Identifying people who need Tier 4 services

People who need Tier 4 services may be:

> at risk of moving up into more intensive PD or secure services because of risk to self or challenge to community services

> offenders in criminal justice or secure settings who can move down into less intensive services as their risk to others reduces or is managed

> other population groups with complex needs, where need has not been clearly identified but who would meet the criteria for diagnosis of PD – for example, women offenders with complex needs.

Distinguishing severe and complex PD should take into account:

> complexity of PD diagnosis

> pervasiveness (extent to which PD impacts on all areas of life)

> complexity of other/associated behaviours and problems

> level of risk

> unmanageability (difficult to manage in community services settings)

> need for residential treatment

> improved forensic risk profile (for patients who may be ready to step down for treatment in secure settings)

> motivation and readiness for treatment.

18.3 Severe and complex personality disorder profiles

A number of profiles are provided to illustrate the range of people with severe and complex PD who may need some kind of residential or more intensive package of care than Tier 3 services can provide.

These include:

- those who experience occasional psychosis-like states
- adults with chaotic lifestyles
- those at high risk of self-harm or suicide
- women at risk of self-harm or suicide
- male adults with ASPD ready to move from Tier 5 or other secure services
- women offenders released from prison
- women at risk of incarceration for low-level offences
- women who have completed treatment in secure settings
- people with very complex needs and co-morbidities.

Further detail is provided in Annex 4.

To meet these diverse needs a range of services could include:

- arrangements for specialist assessment for those with very complex presentations and co-morbidities
- enhanced Tier 3 packages
- specialist Tier 4 residential services
- specialist Tier 4 'step-down' services for men
- specialist residential Tier 4 services for women.

Further details of services and possible commissioning arrangements are provided in Annex 5.

18.4 Making Tier 4 services effective

Experience has demonstrated the following essential characteristics of effective treatment strategies for severe PD.

At **local** level:

- **Appropriate assessment**
  Before referral to Tier 4 services, clients should be assessed by a clinician skilled and trained in PD to ensure that the placement is appropriate and that clients are ready.
- **Established and ongoing local case management/CPA**
  Clients going to Tier 4 services should have established and ongoing local case management to ensure smooth pathways and timely access to other recovery services.

  For non-forensic clients this should be the local PD Tier 3 service or another appropriate service. For forensic clients this should be the local forensic community PD team or another appropriate service.

By **specialist** services providing:

> **Close collaboration in pathway planning**
PD Tier 4 services need to work closely with local services to help clients maintain their links to the community and to ensure a smooth transition into recovery.

> **Specialist consultation and liaison**
Specialist services should provide consultation, liaison and advice to local services to facilitate workforce development and access to other services.

> **Workforce education and training**
Tier 4 services should help with developing and delivering PD training across agencies.

19 Commissioning for Tier 5

19.1 Services for people with severe personality disorder who present significant risk of harm to others

There are four dedicated pilot services for men with severe PD who present a high risk to others.

These have extended our learning in relation to:

> developing pathways from community living through to DSPD/high secure services

> appropriate treatments and interventions

> developing a capable workforce for this challenging group.

The pilots use three main service elements:

> **Secure in-patient services**
Dedicated personality disorder treatment units within medium secure settings.

> **Managed community accommodation**
To provide improved opportunities for rehabilitation and recovery within a framework that ensures public safety.

> **Community case management teams**
Providing support and treatment for clients living in the community, and those who have moved on from other parts of the PD services.

The pilots use a range of long-term clinical approaches aimed at:

> offending behaviours

> violence and aggression (violence reduction and sex offender programmes)

> substance misuse.

The pilot services also provide support to local MAPPA and some training and support to local agencies.

Because these are services that take several years to develop and to demonstrate their effectiveness, the learning from these pilots does not yet allow a clear specification for Tier 5 services.

However, it is possible to highlight certain key issues and to outline a **clear direction of travel** for the future.

19.2 Key issues for service provision

At Tier 5 key issues include:

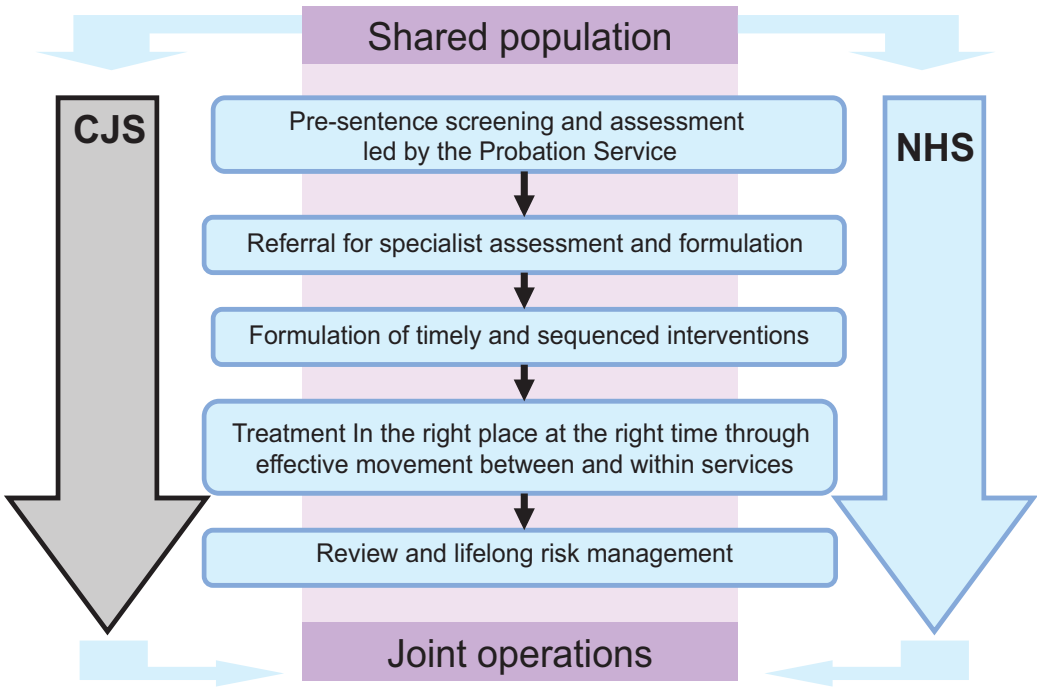
> **Therapeutic approaches and models**
It is clear that a variety of different models and approaches may prove helpful, that models need to be clearly thought through and articulated and that staff need to understand these models fully and the implication for their roles.

> **Service elements and components**
Secure treatment units, community teams and managed accommodation all contribute to local care systems for personality-disordered offenders. Services should be integrated and operate as a single system.

> **The quality of staff and their capacity for therapeutic relationships**
This is a critical success factor. Recruitment should focus on specific personality features and training should focus on equipping staff to work with people with PD. Appropriate supervision and ongoing training are essential.

> **Effective partnership**
Joint work and collaboration with criminal justice agencies is a key feature of services for rehabilitating personality-disordered offenders back into society, as illustrated below.

Joint pathways and management



19.3 The future direction of travel

Learning from the pilots and other sources as well as consideration of the implications of the Mental Health Act 2007 have clarified two essential themes for future services:

> the development of **a joint criminal justice system and health approach** to managing cases and pathways; and

> the gradual development of a **fully co-ordinated service system across custodial, secure and community provision** (i.e. across all services where clients present).

These are further reinforced by the recommendations of the Bradley Review.[29]

[29] Bradley, Rt Hon The Lord Keith (2009)

Building on these foundations would provide a system in which:

> the NHS and criminal justice system agencies would jointly hold responsibility for the population of personality-disordered offenders who present a risk to others, thus promoting public and judicial confidence

> joint case and pathways management systems would ensure appropriate screening, assessment, intervention, placement, risk management and monitoring at key points in the pathway across agencies

> screening and assessment would ensure personality-disordered high-harm offenders are identified early to inform sentence planning and longer-term management

> severe personality-disordered high-harm offenders are managed for life

> co-ordination of provision across prison, hospital, approved premises, community facilities and community-based management would ensure ease of movement through the pathway and between community and residential services.

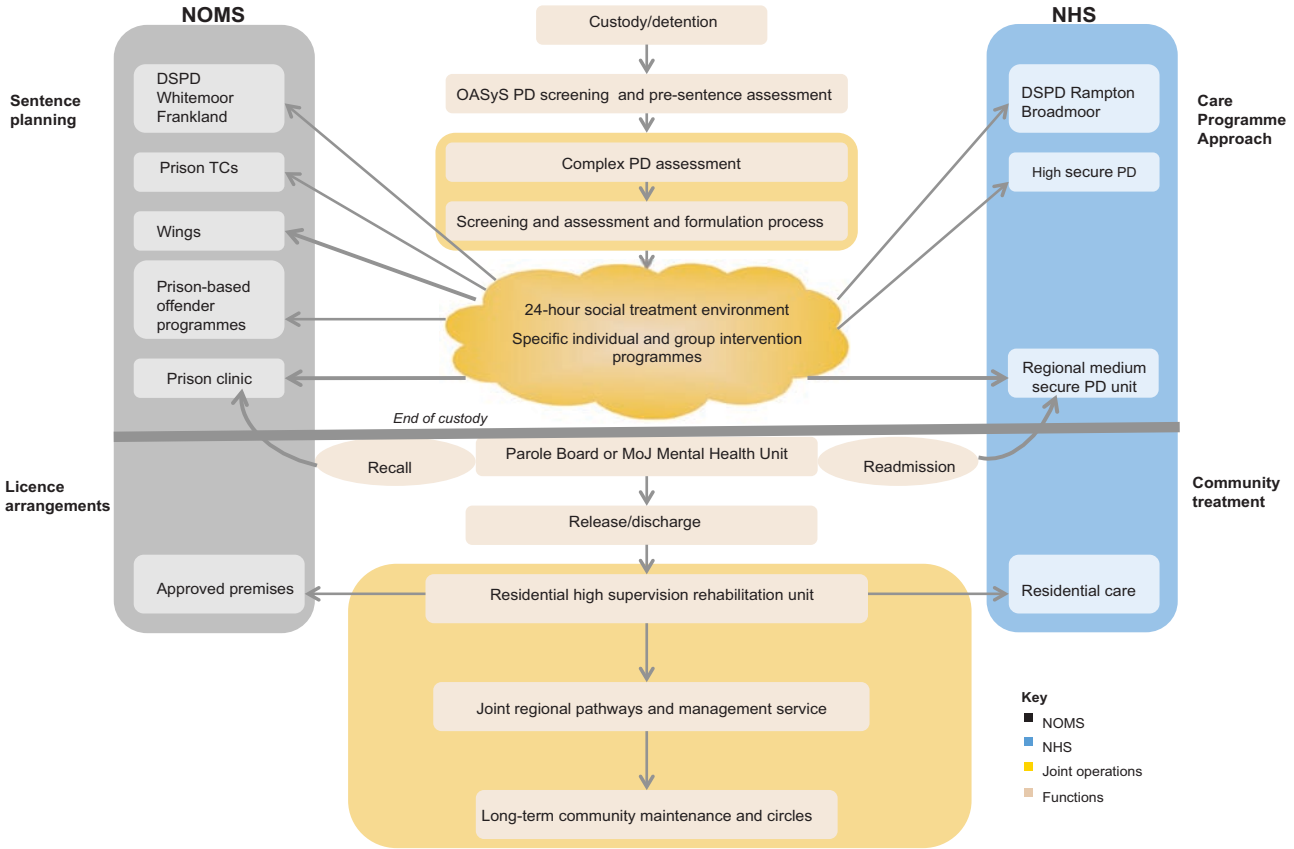
The gradual development of such services depends on collaboration at both commissioning and service provision levels, including:

> collaborative commissioning arrangements between the criminal justice system and the NHS

> community commissioning partnerships through informed and careful use of local strategic partnerships and joint strategic needs assessments

> close working relationships across agencies responsible for movement between settings and those providing services.

A regional joint forensic PD system



In many areas service capacity and experience of joint working will be limited, and making progress towards the ambitious vision outlined opposite may present a challenge.

Long-term plans that gradually build provision and strengthen partnerships are important.

Partners can start the process of change by:

> providing joint PD training for probation, other criminal justice staff and mental health staff

> strengthening the PD capacity of secure services, forensic community teams and dedicated PD services so that skilled support can be made available to probation and other criminal justice staff

> reviewing offender screening and assessment systems to ensure early identification of high-harm personality-disordered offenders

> reviewing the potential for requiring PD treatment within residential probation orders

> focused joint work to co-ordinate practice in sentence planning and CPA.

Part D:
Commissioning for groups with particular needs

20 Groups with particular needs

PD may be overlooked in some client groups because of other more obvious or immediate needs, or perhaps because lack of research knowledge limits our understanding.

While it can sometimes be difficult to be clear about what action is needed, it remains important in the commissioning process to carefully consider a number of groups with particular needs.

20.1 People with less serious personality disorders

Because of difficulties in defining severity and limitations in diagnostic categorisations, relatively little is known about people with less serious PD. They may present to primary care staff with depression, anxiety, drug or alcohol problems, or physical symptoms and underlying personality problems may go unrecognised.

Commissioners should ensure that:

> mental health and substance misuse training offered to primary care staff adequately addresses PD

> primary care-based mental health services (including IAPT initiatives) identify people with PD so that they receive appropriate treatment and those with more serious problems are referred on

> dedicated PD services offer support and consultation to local agencies.

20.2 Personality-disordered offenders with less serious problems

There are significant numbers of personality-disordered offenders who do not present a high risk of harm to others. In prisons and in the community this group experiences complex problems including offending, common mental health problems, substance misuse, enduring interpersonal problems and social disadvantage.

Commissioners across health and criminal justice system agencies should collaborate to ensure that:

> health needs assessments of offender populations properly consider the impact of PD

> mental health prison in-reach services are comprehensive and address the complex needs profile of PD, common mental health problems, substance misuse and self-harm

> low-intensity psychological therapies are available as part of prison in-reach services

> proposed resettlement planning systems routinely consider the impact of PD

> the Knowledge and Understanding Framework PD training and education packages are provided for medical and criminal justice system staff

> the needs of personality-disordered offenders are addressed in plans for community PD services

> personality disordered offenders have access to mainstream services where appropriate

> PD services and drug and alcohol services collaborate to develop focused and accessible community services.

20.3 Children, adolescents and young people

PDs arise in childhood and conduct disorders are strong predictors of later ASPD. Pilot services and other initiatives are exploring the degree to which early intervention may prevent the development of problems in adulthood.

One of the pilot PD services has demonstrated that services aimed at young people (16–25 years) with emerging PD can engage a highly troubled group of young people, providing early intervention and support. This service highlights the contribution that can be made by non-statutory agencies firmly rooted in the culture and practice of youth agencies.

Multi systemic therapy

Multi systemic therapy (MST) is a manualised family and community treatment programme developed in the US for young people with complex needs.

> *'If a teacher had known about PD when I was a child, I may not have had the path in life I did.'*

Currently, the Social Exclusion Action Plan has initiated 12 researched MST pilot services aimed at 11–17-year-olds focusing on a younger group at risk of developing PD. The NICE guideline on ASPD recommends considering use of this model for young people with severe conduct disorders and a history of offending. The guideline also recommends a range of other interventions. The pilot programme will further clarify best practice in terms of interventions and service models.

Until the research evidence further clarifies required interventions and service models, commissioners should:

- ensure that local mental health needs assessments of children and young people, as required by *A comprehensive CAMHS*,[30] specifically consider children and young people at risk of developing PD
- ensure that a range of preventative and early intervention strategies is developed for children and young people at risk of developing PD in adulthood (as recommended by the NICE guideline for ASPD)
- consider the potential benefits of provision through independent sector agencies rooted in the youth culture for young people in the 16–25 years age group with emerging PD.

20.4 Women with complex needs

Within the criminal justice system and health services we see women with PD and complex needs who are likely to have:

- endured significant sexual and other abuse in childhood and adulthood
- experienced disrupted care as a child and been 'looked after' or fostered
- low educational attainment with little or no experience of training or employment
- experienced multiple or long periods of care or imprisonment
- complex diagnoses of PD, mental illness, eating disorders etc

[30] Department of Health and Department for Education and Skills (2007)

- offending profiles but rarely present risk to others
- received a label of 'challenging' or 'difficult to manage'
- experience of eating difficulties, fire setting, substance misuse and using self-injury as a coping mechanism.

They may also have experienced the loss of their children.

Commissioners should ensure that:

- health needs assessments of offender populations explicitly consider the needs of women offenders with PD
- capacity planning is effectively used to ensure that the needs of women with PD and complex needs for Tier 4 and other intensive services are addressed.

20.5 Black and minority ethnic groups

Probably because of long-standing patterns of misdiagnosis, over-representation in in-patient and secure services, and low access to talking therapies, people from black and minority ethnic communities use PD services at lower rates than the white population.

Commissioners and trusts should ensure that:

- access by black and minority ethnic residents to services provided for people with PD is routinely monitored and reviewed to ensure racial and cultural appropriateness
- the racial and ethnic profile of the workforce providing services for people with PD reflects that of the local population. Link worker posts may be helpful in providing information about services to particular population groups and in improving access
- training programmes alert staff to issues relating to PD and minority ethnic populations
- services promote equality of opportunity and good community relations.

20.6 Personality disorder and substance misuse or dependence

Many individuals with PD also misuse drugs or alcohol as a way of managing overwhelming emotions. Evidence and experience suggest that simultaneous psychological treatment and reduction in substance misuse provide the best chance of a successful outcome.

Annex 6 provides best practice information on how mental health and substance misuse services can collaborate to address need.

20.7 Older adults

The UK has an ageing population. Residential and non-residential services for older people should be aware of the possibility of PD in their clients.

A clear diagnosis of PD in older adults can be difficult due to lack of information about the person's earlier life, or co-morbidity with age-related diseases such as the dementias.

The interventions that may be helpful to younger people with PD may also be useful for older adults.

Commissioners and trusts should ensure that:

> staff are trained in PD and some staff in assessment and diagnostic skills

> a broad range of psychological therapies is available for older adults

> there are joint protocols and treatment strategies across agencies to meet the needs of older adults with PD

> a coherent service model is developed to manage older adults with PD.

In some areas commissioners may consider specific needs assessment exercises to ensure that they fully understand the nature and scope of local needs and how existing services are responding.

20.8 People with learning disability and personality disorder

People with learning disability (LD) and PD often present with complex problems and may need significant levels of support. They are able to live in the community but need improved assessment, diagnosis and specialist support services.

Commissioners and trusts should ensure that:

> young people with LD and PD, particularly those likely to have complex and severe problems, are identified early and offered focused support

> staff recognise the importance of understanding the needs of people with PD and LD and are provided with training as necessary

> staff in specialist services are motivated, trained and supported in working with this client group

> specialist staff in both disciplines are available to ensure effective assessment, risk assessment, treatment and support

> specialist staff in both disciplines liaise regarding diagnosis and treatment

> consideration is given to whether this group is best catered for within mainstream LD or specialist PD services and appropriate services developed

> wherever possible crises should be prevented through long-term support and management

> facilities are available to meet occasional crisis needs for residential safety and treatment.

In some areas commissioners may consider specific needs assessment exercises to ensure that they fully understand the nature and scope of local needs and how existing services are responding.

21 Summary of commissioning guidance

21.1 Foundations of effective commissioning

Aims	Activities	Potential outputs – PD populations
Partnerships	Establishing inter-agency partnerships necessary for PD commissioning.	Co-commissioning or aligned commissioning agreements established with local criminal justice system agencies in respect of 'high-harm' personality-disordered offenders. Inter-agency partnership or network established to address needs of women with severe and complex PD. Needs of particular groups with PD addressed within local joint strategic needs assessment.
Integrating PD across health and other public services	Ensuring that PD implications are recognised and addressed in policy implementation in: • mental health services • psychological therapies • substance misuse services • offender health and rehabilitation services • women's mental health • primary care services • CAMHS • services designed to reduce social exclusion etc.	Commissioning culture and dialogue that recognises PD and complex need across a wide range of client groups and agencies. Early identification of people with PD through improved access to psychological therapies. Comprehensive offender health and prison in-reach services that effectively address complex need profiles. Informed links between social inclusion initiatives and PD programmes.

21.2 Effective commissioning process

Aims	Activities	Potential outputs – PD populations
Needs assessment	Ensuring that: • needs of people with PD are addressed within assessments of offender populations • needs of women with PD are addressed within assessments of offender populations • local needs assessments of children and young people at risk include those at risk of developing PDs • needs of diverse groups of people with severe and complex PD are assessed (particularly women with complex needs) • specific needs assessments of older people with PD and people with LD and PD are undertaken where deemed necessary • systematic information gathering is used to improve understanding of the needs of people with PD from black and minority ethnic communities.	Informed commissioning across agencies. Improved understanding of the needs of particular population groups and more sensitive services. Improved understanding and improved services help to reduce health inequalities.
Outcomes	Using health and process outcomes in commissioning.	Focused and effective dedicated PD services. Mainstream services that can provide appropriate response and support to people with PD.
Quality	Supporting service providers to recruit, train, support and retain a high-quality workforce. Using Knowledge and Understanding Framework products as they become available. Using existing quality assurance processes for TCs. Involving service users in service development and operation, and in commissioning.	Stable, skilled and motivated workforce for PD services. Workforce in mainstream services that is competent and confident regarding PD. Services that are sensitive and responsive to people with PD. Services that are motivated to strive for continuous improvement.
Comprehensive services: effective pathways	Distinguishing levels of severity in PD and developing services to meet different levels of need. Using 'whole systems'/tiered models to ensure co-ordinated services and pathways. Developing the role of mainstream mental health services as well as dedicated PD services. Reducing health inequalities through comprehensive service provision that is sensitive to the needs of all population groups.	More efficient use of highly specialist resources. Improved management of transitions between criminal justice system and NHS services. Increase in numbers of people with PD receiving services close to home.

21.3 Commissioning effective services

Aims	Activities	Potential outputs – PD populations
Services for people with moderate to severe PD (Tiers 1–3)	For populations of 300,000–1,000,000, securing community-based services that provide: • flexible and appropriate access • engagement • case management/CPA • advice and information • assessment • one-to-one interventions and therapy • group interventions and therapy • crisis management and support • support into recovery • peer group support. Also close joint work with other agencies, consultation, education and training, client assessment and preparation for more specialist services.	More effective use of existing mainstream and specialist mental health services. Improved mental well-being. Increase in numbers of clients in settled and stable lifestyles. Reduced use of emergency services, A&E and psychiatric in-patient care. Long-term treatment strategies and improved management of small numbers of people with severe problems.
Services for people with severe and complex PD (Tier 4)	On a catchment group population basis, taking needs assessment into account, securing a range of services to meet the needs of small, diverse population groups.	Improved mental well-being. Increase in numbers of clients in settled and stable lifestyles.
Services for people with severe PD and high risk of harm to others (Tier 5)	For populations of 1,000,000–3,000,000, securing services that provide treatment and management in secure settings, long-term community management, pathways into community accommodation, and rehabilitation and recovery. Also, for **future direction of travel**, the gradual development of: • **joint criminal justice system and health approach to case and pathways management**, ensuring early identification and assessment, and the right treatment in the right place at the right time • **co-ordinated service systems across custodial, secure and community services.**	Long-term treatment strategies and improved management of people with severe problems who present risk. Reduced risk to public.

21.4 Commissioning for groups with particular needs

Aims	Activities	Potential outputs – PD populations
Ensuring that PD is recognised and appropriately addressed in commissioning for particular population groups. Ensuring that specialist staff across services work jointly for effective assessment and support. Ensuring early identification and intervention.	**Those with less serious PD** Improved response across health and other public services to population groups with complex needs where PD may be unrecognised. Ensuring recognition of PD in design of primary care mental health services. Supporting primary care in dealing with people with PD. **Personality-disordered offenders with less serious problems** Improving systems to identify offenders with PD, particularly those presenting a risk to self or others. Developing comprehensive prison in-reach services that address co-morbid PD, substance misuse and self-harm. Ensuring resettlement services address the needs of offenders with PD. **Children and young people (*future direction of travel*)** Gradual development of early identification and intervention for children at risk of developing PD in later life (11–17 years), and young people with emerging PD (16–25 years). **Black and minority ethnic groups** Routine monitoring and review of access to PD services. Ensuring appropriate racial/ethnic profile in workforce. Ensuring that training programmes address relevant issues. **Women with complex needs** Securing effective prison in-reach and Tier 4 services. Ensuring effective self-harm interventions across NHS and criminal justice system services. **People with PD and substance misuse** Appropriate training across PD and substance misuse services workforce. Shared care protocols across PD and substance misuse services to ensure appropriate access and provision. Simultaneous reduction in substance misuse and psychological treatment. Shared care protocols across PD and substance misuse services to ensure appropriate access and provision. Simultaneous reduction in substance misuse and psychological treatment. Effective management of risk. **Older adults** Ensuring staff training in PD and assessment/diagnosis skills for selected staff. Ensuring that a broad range of psychological therapies is available for older people with PD. Establishing joint protocols and treatment strategies across agencies. **People with LD and PD** Ensuring staff training, supervision and support in relation to PD. Ensuring that specialist staff across services work jointly for effective assessment and support. Ensuring early identification and intervention.	Improved response across health and other public services to population groups with complex needs where PD may be unrecognised. Improved understanding of needs, and service provision sensitive to the needs of diverse population groups helps to reduce health inequalities.

Annexes

Annex 1: Public Service Agreements and personality disorder

PSA	Key PD-related topic	Commissioning issues
12	**Emotional health and well-being of children and young people** • Ensuring that child and adolescent mental health services (CAMHS) provide a comprehensive service for their area (appropriate accommodation and support for 16–17-year-olds; 24-hour urgent response; early intervention and support).	• Early identification and support for children at risk of developing personality disorders (PDs) in adult life (e.g. conduct disorders in children of personality disordered or mentally disordered parents). • Effective screening to identify those most at risk of developing serious PD in adult life, and provision of appropriate programmes. • Early intervention and support for young people with emerging PDs (e.g. socially excluded, care leavers). • Emerging PDs are frequently associated with substance misuse: early identification and support strategies should incorporate appropriate help for substance misuse. • Appropriate early intervention strategies to contribute to reducing numbers of young entrants to the criminal justice system.
14	**Increase the number of children and young people on the path to success** • Reduce the proportion of young people harmfully using substances. • Reduce number of first-time entrants to the criminal justice system aged 10–17.	
16	**Increase the proportion of socially excluded adults in settled accommodation, employment, education and training** Focus on key at-risk groups: • care leavers • adult offenders under probation supervision • adults in contact with mental health services • adults with moderate to severe learning disabilities.	• Appropriate services for young people with emerging PDs will help care leavers to achieve settled lifestyles. • Appropriate move-on for those leaving dangerous and severe PD (DSPD) and other secure PD services. • Appropriate services for people with PDs should help adults in contact with mental health services to achieve settled lifestyles. Services should promote recovery and social functioning outcomes. • Better support for adults with learning disability (LD) and PD will help them to achieve stable and independent lifestyles.
18	**Promote better health and well-being for all** • Continued reduction in death by suicide and undetermined injury (including prison population). • Improving access to psychological therapies for mild to moderate depression and anxiety disorders.	• Services to promote health and well-being for people with PD and personality-disordered offenders. • Identification of, and support and services for, those at high risk of suicide – e.g. people with PD who self-harm, prisoners with antisocial PD (ASPD)/ borderline PD (BPD), people with PD and substance misuse problems. • Access to appropriate psychological therapies for people with PD also suffering depression and anxiety. • Services with the capacity to identify people with PD who require additional treatment and support.
23	**Make communities safer** • Reduce the most serious violence, serious sexual offences and domestic violence. • Reduce reoffending through improved management of offenders.	• Services for offenders identified as having DSPD who present most serious risk. • Joint criminal justice system/NHS pathway management for offenders with DSPD and other PD where appropriate. • Assess need for planned interventions for prisoners on indeterminate sentences.
25	**Reduce the harm caused by alcohol and drugs** • Improving access to advice, treatment and support for those harmfully using drugs and alcohol in the community and in prison. • Reducing the rate of alcohol-related hospital admissions. • Reducing the rate of drug-related offending.	• Appropriate treatment options for people and offenders with PD who use alcohol and drugs harmfully. • Appropriate treatment and support for people with PD and co-morbid substance misuse is likely to reduce emergency or urgent hospital admissions which may be alcohol related and the rate of drug-related offending.

Annex 2: Identifying levels of severity

Population/severity	Criteria	Services required
Those at risk of developing PD or with emerging PD Seriously socially excluded children, looked-after children, young people with emerging personality problems	**Children/young people at risk (from multi systemic therapy (MST) pilots)** • Young people aged 11–17 years • At risk of entering care due to serious behavioural difficulties • At risk of being placed out of home due to offending • At risk of being placed away from home in an educational placement • Complex difficulties with the young person and family which cannot be dealt with easily by existing services • Where parents or carers have significant difficulties which affect their parenting (e.g. substance misuse) **Young people with emerging PD (from Zone[31])** • Young people aged 16–25 years • No previous or current mental health service involvement • Emotional distress, damaging patterns of behaviour and problems with day-to-day living • Significant feelings of exclusion or detachment • Without help likely to be labelled with a PD in later life	Upstream societal programmes Social and emotional health promotion initiatives Early identification and intervention services Multi-agency approaches For some groups: • specific individual, group and residential interventions • longer-term pathway planning and continuity
Less serious PD	• Normally able to function (e.g. living within stable family, mostly able to work, few extra demands on health services, little risk of harm to self or others) • At times of stress may present to health or justice services • International Personality Disorder Examination (IPDE)[32] <30 • Single or one cluster diagnosis, not ASPD	Occasional support through family, community and mainstream public services Tier 1 agencies will need advice, support and education from PD services

[31] The Zone Pilot, Plymouth in Gilbert, T. et al (2006)
[32] Loranger, A., Sartorius, N. et al (1994)

Annex 2: Identifying levels of severity (continued)

Population/severity	Criteria	Services required
Moderate to severe PD	• Vulnerable at all times • Often involved with health, justice or other statutory services • Spells of normal functioning usually short-lived and disproportionately disrupted by relatively minor stresses or perceived rejections • Families generally dysfunctional • Variable but continuous risk of harm to self, self-neglect or consequences of impulsive behaviour • Little direct risk of harm to others, but can be significant burden to families, friends and carers • IPDE 25–45 • More than one cluster diagnosis, although rarely including ASPD	Dedicated PD services at Tiers 1–3
Severe and complex PD	• Range of different sub-groups but mostly continuously involved with health, justice and other statutory services • No settled home, family or work • Considerable and continuous risk of harm to self and frequent impulsive behaviour • Major problems in all areas of life, frequent hospitalisations or imprisonments • IPDE >40 • Some sub-groups with mixed diagnoses, some sub-groups including ASPD • Diagnosis – multiple PDs • Pervasiveness – severe impacts in many areas of life • Complexity – several co-morbidities, offending behaviours • Risk – persistent and/or life-threatening behaviours, high risk of harm to self • unmanageability – difficult to manage in community settings Criteria for referral to Tier 4 services: • unmanageability • upecific need for residential treatment • improved forensic risk profile • motivation and readiness for change	Dedicated PD services at Tier 4 Tier 5 services for health and criminal justice system pathway

Population/severity	Criteria	Services required
'High-harm-to-others' PD, including dangerous and severe PD Degree of risk, severity and offence determine whether individuals are deemed high harm or very high harm, and whether they require Tier 5 or Tier 6 services	**Children/young people at risk (from MST pilots)** • High PCL-R[33] score: – Women 25+ – Men 30+ *Or* • High PCL-R score + PDs: – Women 18–24 + 2 or more PDs other than ASPD – Men 25–29 + 1 or more PDs other than ASPD *Or* • Multiple PDs: – Women: at least 3 – Men: 2 or more *Criteria for referral to Tier 6 services* • Likelihood of committing serious physical or psychological harm to others • Identifiable severe PD as above • Evidential link between PD and offending	Tier 5 dedicated PD secure services and comprehensive, lifelong community management Tier 6 DSPD treatment units in NHS high secure hospitals and prisons Prison therapeutic communities (TCs) and post-tariff case management

[33] *The Hare Psychopathy Checklist – Revised*, a diagnostic tool used to rate psychopathic or antisocial tendencies

Annex 3: Personality disorder services: key practice features

- Services should be delivered over a relatively long period of time – years rather than months.
- Services should be consistent and reliable.
- Communication within staff teams is vital – services should have a clear information-sharing policy that is explained to clients during induction.
- Teams should be made up of people from a range of both professional and non-professional backgrounds.
- Users and their carers should be involved in making decisions about service development.
- Responsibility for clients should be shared by members of a team and/or the community.
- Limits on the availability of staff and other boundaries need to be made clear at the start and maintained throughout treatment.
- Services need to demonstrate that clients are valued and valuable. They should validate clients' experience and aim to increase self-acceptance.
- Short and long-term goals should be negotiated with clients at an early stage.
- Services should provide and promote choice, self-efficacy and personal responsibility and avoid trying to control or coerce clients.
- Services need to be able to deliver social as well as psychological interventions.
- Services should be able to arrange for more intensive services at times of crisis, including home treatment and/or residential care.
- Services should try to obtain clients' consent to contact, support and inform carers.
- Systems should be in place for ensuring that the leaving process is made clear and discussed well in advance.
- Services should be culturally sensitive and mindful of clients' experiences of discrimination on the basis of race and ethnicity.

Annex 4: Profiles: severe and complex personality disorder

Profile	Description	Services needed
1 Those who experience occasional psychosis-like states	Men or women with severe PD, most commonly BPD, who experience occasional psychosis-like states and may be at significant risk to themselves. Where the client lives in a family group, or with a parent, there may be risk of severe impact on family or children.	• Safe containment and treatment and management within a residential setting. *Or* • A local enhanced package – treatment on a community basis from an intensive PD service, with access to safe residential management when necessary (e.g. NHS acute care or possibly high-staffed residential care).
2 Adults with chaotic lifestyles	Adults, sometimes young adults of both sexes, with severe and complex PD, most commonly BPD and associated substance misuse, who present a self-harm risk, who have severely unstable/chaotic lifestyles and who are homeless.	• Treatment and management within a residential setting. *Or* • A co-ordinated, enhanced local package of care that includes supported residential hostel or housing with intensive community-based treatment.
3 Those at high risk of self-harm or suicide	Adults, sometimes young adults, with severe and complex PD, most commonly BPD and associated co-morbidities, who are experiencing a period of acute and severe self-harm or suicide risk. Where the client lives in a family group, or with a parent, there may be risk of severe impact on family or children.	• A period of acute care followed by intensive community-based treatment.
4 Women at risk of self-harm or suicide	Women with severe and complex PD, most commonly BPD and associated co-morbidities, who present with chronic and very severe self-harming behaviours or suicide risk. Where the client lives in a family group, or with a parent, there may be risk of severe impact on family or children.	• Residential treatment option, followed by rehabilitation, possibly in a women's treatment unit. *Or* • High Support Therapeutic Community Residential Services (HSTCRS) type service and later intensive community treatment.
5 Male adults with ASPD	Male adults with ASPD who have been assessed as presenting 'high harm' risk, who have completed a period of treatment within DSPD medium secure units and who are now felt to be ready to move on.	• Treatment in a residential, planned therapeutic environment to allow further rehabilitation and to test risk before resettlement in the community.
6 Women offenders released from prison	Women offenders with complex PD and associated co-morbidities and social problems, usually with self-harm behaviours and suicide risk, who are vulnerable within prison, in the community and on release from prison. The Corston Report[34] indicates that on discharge from prison the most pressing need is accommodation.	• Residential treatment with a rehabilitative focus *Or* • HSTCRS-type service. *Or* • Long-term structured hostel or managed accommodation placement, and intensive community-based treatment. Assessment and preparation could start within the prison setting through collaboration between prison staff and PD services.

[34] Home Office (2007)

Annex 4: Profiles: severe and complex personality disorder (continued)

Profile	Description	Services needed
7 Women at risk of incarceration for low-level offences	Women, including young women, with complex PD and co-morbidities who may be at risk of incarceration for low-level offences and who could be diverted with appropriate treatment packages.	• HSTCRS-type service. *Or* • Complex enhanced packages combining elements of criminal justice system programmes (probation/community supervision, Tier 3 PD services, hostel/ community accommodation, parenting/ family support etc).
8 Women who have completed treatment in secure settings	Women with severe and complex PD and associated co-morbidities and social problems, usually with self-harm behaviours and suicide risk, and low-level offending behaviours. They have completed treatment in a secure setting, possibly in the private sector, and are now felt to be ready to move on.	• Treatment in a residential, planned therapeutic environment. *Or* • HSTCRS-type service, for further rehabilitation and to test risk before resettlement in the community.
9 Those with very complex needs	People with very complex presentations which may indicate particular co-morbidities (e.g. PD/LD/substance misuse) or significant personality change following head injury or where a cocktail of prescribed and/or illicit substances clouds the presentations, and where a specialist assessment is needed.	• Individually organised assessment from skilled practitioners in a range of specialisms including PD, preferably on an outreach basis. *Or* • Residential assessment using local facilities in collaboration with relevant specialists, followed by community treatment and support through co-ordinated input from specialist LD, substance misuse, PD Tier 3 or other relevant services.

Annex 5: Commissioning: severe and complex personality disorder

Service	Description	Commissioning
Specialist assessment services for those with very complex presentations	Where co-morbidities (particularly LD, autistic spectrum disorders, head injury, organic conditions, severe systemic family dysfunction and enduring damage from addictions) render usual treatment options inappropriate, joint assessment is required with the relevant specialist input. Where this cannot be provided by a local PD service (for example because it requires residential care in a planned environment), facilities need to be available in these complex and severe PD services.	Complex commissioning may involve several NHS and local authority commissioning partners in a range of configurations depending on the particular client's needs. This could include other relevant clinical specialties, e.g. LD, head injury etc.
Enhanced Tier 3 service packages	Already established, dedicated community PD services enhanced by other local services within a co-ordinated package of care, to support community containment and treatment for people with severe needs. Additional service elements might include: • NHS acute care: suitable staffed beds in admission wards, and other options • occasional and planned access to short-term beds in NHS hospitals • high-staffed or suitably structured residential accommodation (possibly in the voluntary sector) • social care crisis facilities • access to 24/7 support. Case co-ordination management is carried out by PD Tier 3 service and becomes a crucial element. Voluntary sector and other participating agencies likely to need support and training from skilled PD teams.	Local joint commissioning involving primary care trusts (PCTs) and local authorities as determined by local circumstances. Dedicated pooled budgets would facilitate this. Commissioner contracts with providers who operate managed networks, which would also allow further development of suitable arrangements.
Specialist Tier 4 residential services	To provide for clients who: • are at high risk of suicide • have very unstable lifestyles • have a history of unstable accommodation or homelessness (in addition to clear treatment needs and suitability) • cannot be managed in Tier 3 services or by enhanced Tier 3 packages. Might include democratic TC or other TC models, but should also be able to accept a more diverse range of clients than residential TCs are able to do (e.g. vulnerable women coming out of prison). Should be able to address severe substance misuse as part of complex need. To ensure effectiveness, services should work closely with local PD case co-ordination services.	Lead PCT or specialised commissioning group (SCG) commissioning.

Annex 5: Commissioning: severe and complex personality disorder (continued)

Service	Description	Commissioning
Specialist Tier 4 residential step-down services for men	To provide a stepped stage of rehabilitation for men who have presented high risk of harm to others and undergone specialist treatment within DSPD, therapeutic prison programmes or medium secure services. A residential, planned and managed therapeutic environment will enable services to test improved risk levels and assess and develop preparedness for safe community living. To ensure effectiveness of this stage of treatment, services should work closely with local forensic PD case co-ordination services.	Lead PCT or SCG and regional offender managers (ROMs) commissioning.
Specialist residential Tier 4 services for women	As numbers in any of the diverse sub-groups of severely disordered women are small, there is a case for women's PD units that meet a range of needs. These would serve women who are: • at serious risk of suicide or self-harm • in danger of moving up tiers into more secure services • moving down from secure services • vulnerable with complex needs coming out of prison • vulnerable with severe and complex needs at risk of incarceration. There are common psychosocial treatment needs across these groups in relation to abusive histories, self-harm behaviours and suicide risk, substance misuse and other co-morbidities. Residential services would combine therapeutic treatment with a rehabilitation ethos for severely disrupted lives. They could be based on TC or other treatment models and a degree of relational security may be necessary in some parts of the service.	Lead PCT or SCG and ROMs commissioning.

Annex 6: Best practice in addressing dual diagnosis of personality disorder and substance misuse

Commissioners and trusts should ensure that:

> staff in drug and alcohol teams are trained in the recognition and assessment of PD

> staff in PD services are trained in the recognition and assessment of substance misuse/ dependence

> joint ongoing supervision is provided between substance misuse and specialist PD services

> dual diagnosis staff across all services are provided with training and supervision in the recognition and treatment of PD

> shared care protocols are established so that reduction in substance misuse is undertaken simultaneously with the provision of psychological treatment for PD to allow for the best chance of a successful outcome

> shared care protocols include jointly agreed responses to relapse and to risk, clear goals for each treatment/service, and regular and good quality communication

> specialist PD services, drug and alcohol teams, and all mental health front-line staff working with PD and substance misuse receive training in motivation enhancement (Motivational Interviewing) techniques

> services for PD and substance misuse provide advice and support for attending harm minimisation and sexual health clinics to reduce the risk of blood-borne viruses

> intervention programmes provide information and support on returning to education as a means of eventually engaging in vocational activity.

The recommendations apply to services provided in the community for less severe PD, to secure settings for PD, and to services provided within the prison system for PD and substance-misusing offenders.

Annex 7: World Class Commissioning and personality disorder

Local leadership

Improving services for people with PD presents particular challenges related to complex need and the complex and wide-ranging response required, so effective leadership is essential for commissioning services and systems that address PD.

PCT commissioners need to demonstrate that:

> key stakeholders strongly agree that you are proactively commissioning comprehensive services for people with PD rather than responding to providers' intentions to provide specific or generic services

> you actively encourage commissioners across a wide range of health services (e.g. prison health services, services for children and adolescents, primary care services) to understand the impact of PD and to address it where appropriate and possible

> you actively participate in and share leadership of the local PD agenda, effectively engaging relevant multi-agency groups and partnership processes

> local people strongly agree that the local NHS is improving services for people with PD.

Collaborative working

PD cuts across all areas of life, with impacts throughout an individual's life and across agencies and sectors. For this reason it is important for PCTs to form partnerships and collaborate with other key stakeholders when commissioning systems and services. In terms of World Class Commissioning this would mean that:

> PCTs actively participate in strategic partnerships with colleagues in social care, criminal justice, children's services and others in order to develop and implement a needs-based strategy for services and systems for people with PD

> the PD strategy includes inter-agency interventions aimed at prevention and early intervention as well as treatment and support

> the PD strategy informs the content of the joint strategic needs assessment

> key stakeholders agree that you proactively engage with their organisation to inform and drive both strategic planning and design services for people with PD.

Engaging with patients and the public

To manage effectively with patients and the public, you need to ensure that:

> you have effective strategies for communicating with the local population in relation to the uptake, safety and efficient use of PD services

> people with PD themselves are involved in the design, delivery and review of existing and new PD services

> the local population strongly agrees that the local NHS listens to the views of local people and acts in their interest

> you have embedded the collection of patient experience data in all contracts with PD service providers.

Clinical engagement

While the National Institute for Health and Clinical Excellence (NICE) guidelines for both BPD and ASPD indicate the best available evidence base for clinical practice, there is a lack of high-quality evidence in this area. So it is important to engage with local clinicians regarding existing and future treatment models.

In relation to World Class Commissioning PCTs need to show that:

- there is clinical engagement in strategy, planning and service development in relation to PD services
- practitioners and managers from other key agencies (e.g. probation and children's services) are similarly engaged in strategy, planning and service development in relation to PD services
- clinical and practitioner engagement supports the ongoing improvement of patient outcomes in PD services
- practice-based commissioners recognise the importance of PD services in mental health patient pathways, and seek to engage providers in the redesign of services
- key stakeholders strongly agree that you proactively engage clinicians to inform and drive both strategic planning and service design of PD services.

Manage knowledge and assess needs

Assessing health and social care needs relating to PD is a challenging task and PCTs may take several years to build a comprehensive understanding of the impact on their local population.

A phased programme might include work to ensure that:

- mental health services data systems capture information on PD
- the needs of people with PD are clearly identified within needs assessments of offender populations
- local needs assessments of children and young people at risk include those at risk of developing PD
- specific work is undertaken to assess the needs of people with severe and complex PD who may need highly specialist or residential services
- systematic information gathering is used to improve the understanding of the needs of people with PD from black and minority ethnic populations
- you use available information on outcomes to analyse the effectiveness of interventions to improve PD services
- you monitor progress towards reducing gaps in PD service provision and develop effective solutions
- you use population risk data to identify communities at risk and intervene promptly with appropriate PD services
- you use available data to identify unmet needs for PD services for disadvantaged groups and are working to improve services to these populations.

Prioritise investment

There is evidence that people with PD often make extensive and chaotic use of a range of services and that providing effective care pathways, treatment and interventions can lead to more efficient use of services and address health inequalities. Therefore investment in PD services and systems should enable PCTs to show that it can secure improved health outcomes.

Stimulate the market

People with PD frequently experience rejection and discrimination across a range of services and areas of life. So a key goal in improving service user experience is through developing the capabilities, skills and knowledge of staff who are dealing with the challenges of PD. The range of services within the statutory, private and third sector organisations are often not well developed for PD. PCTs can use their investment power to improve choices, service design and desired outcomes from a range of local providers.

In relation to PD this means that:

> you are aware of current and future provider capacity and capability, can identify gaps in workforce skills and competencies and take steps to address this

> you encourage provision via third sector organisations, building on local social capital

> you use patient reported outcomes measures to gain a deeper understanding of commissioned PD services.

Promote improvement and innovation

In order to promote improvement and innovation it is important that you:

> work with clinicians to regularly review and agree clinical pathways and engage with opportunities for improvement and innovation

> collaborate with commissioners in other agencies to ensure that opportunities for innovation and improvement in the wider service system are identified

> involve patients, including those in more socially excluded groups, in creating and developing PD services

> become involved in local PD networks that provide information on best practice and innovation

> provide PCT board reports which concentrate on quality and outcomes rather than cost and volume.

Secure procurement skills

As commissioners you need to ensure that:

> negotiation of contracts delivers a positive position for both the PCT and PD service providers, reinforcing strong strategic relationships

> local health services contracts incorporate NICE guidelines, Department of Health commissioning guidance and other relevant policies in relation to PD

> collaboration with other agencies ensures that, where relevant, contracts incorporate best practice indications from NICE, commissioning guidance and other sources relating to PD.

Manage the local health system

You should regularly discuss performance improvement with PD service providers, using performance data and best practice information to improve quality and outcomes, leading to demonstrable change.

Make sound financial investments

In order to ensure that financial investments are sound, it is important that:

> financial strategies in relation to PD take account of key trends and risks and support the overall commissioning strategy

> PCTs ensure that financial investments lead to sustainable development and value for money.

Annex 8: References

Alwin, N., Blackburn, R. et al (2006) *Understanding Personality Disorder: A Report by the British Psychological Society.* BPS, Leicester.

Bradley, Rt Hon The Lord Keith (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. Department of Health.

Cabinet Office (2006) *Reaching Out: An Action Plan on Social Exclusion*.

Casey, P. (2000) The epidemiology of personality disorders. In Tyrer, P. (ed.) *Personality Disorders: Diagnosis, Management and Course*. Wright, London.

Coid, J., Yang, M. (2006) Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry* 188:423–31.

Department for Children, Schools and Families (2007) *The Children's Plan: Building brighter futures.*

Department of Health (2002) *Women's Mental Health: Into the Mainstream – Strategic development of mental health care for women*.

Department of Health (2005a) *Delivering Race Equality in Mental Health Care*.

Department of Health (2005b) *Independence, Well-being and Choice: Our vision for the future of social care for adults in England.*

Department of Health (2007) *Consultation on the Draft Revised Mental Health Act 1983 Code of Practice.*

Department of Health (2008) *Improving Access to Psychological Therapies Implementation Plan: National guidelines for regional delivery.*

Department of Health, Department for Children, Schools and Families, Ministry of Justice, Youth Justice Board and Home Office (2007) *Improving Health, Supporting Justice: A consultation.*

Department of Health and Department for Education and Skills (2007) *National Service Framework for Children, Young People and Maternity Services*. The Mental Health and Psychological Well-being of Children and Young People, Standard 9, Appendix 2: A Comprehensive CAMHS.

Department of Health/Home Office (1999) *Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development.*

Gilbert, T., Farrand, P. and Lankshear, G. (2006) *Evaluation of an Early Intervention Scheme for Young Persons considered 'at risk' of developing a Personality Disorder in the Community covered by Plymouth PCT and South Hams and West Devon PCT*. Second Interim Report. University of Plymouth.

Home Office (2004) *Reducing Re-offending: National Action Plan.*

Home Office (2007) *Corston Report: A Review of Women with Particular Vulnerabilities in the Criminal Justice System*.

Linehan, M., Schmidt, H. et al (1999) Dialectical behavior therapy for patients with borderline personality disorder and drug dependence. *American Journal on Addictions* 8(4):279–92.

Loranger, A., Sartorius, N. et al (1994) The International Personality Disorder Examination: The World Health Organization/Alcohol, Drug Abuse, and Mental Health Administration International Pilot Study of Personality Disorders. *Archives of General Psychiatry* 51(3):215–24.

Martin, R., Cloninger, C. et al (1985) Mortality in a follow-up of 500 psychiatric outpatients. II. Cause-specific mortality. *Archives of General Psychiatry* 42(1):58–66.

Ministry of Justice/NOMS (2008) *National Service Framework: Improving services to women offenders.*

Moran, P. (2002) The epidemiology of personality disorders. *Psychiatry* 1(1):8–11.

Nace, E., Davis, C. and Gaspari, J. (1991) Axis II co-morbidity in substance abusers. *American Journal of Psychiatry* 148:118–20.

National Institute for Health and Clinical Excellence (NICE) (2009a) *Antisocial Personality Disorder Treatment, Management and Prevention*, clinical guideline 77.

National Institute for Mental Health in England (NIMHE) (2003a) *Personality Disorder: No longer a diagnosis of exclusion – Policy implementation guidance for the development of services for people with personality disorder.*

NICE (2009b) *Borderline Personality Disorder, Treatment and Management*, clinical guideline 78.

NIMHE (2003b) *Breaking the Cycle of Rejection. The Personality Disorder Capabilities Framework.*

Singleton, N., Meltzer, H. et al (1998) *Study of Psychiatric Morbidity Among Prisoners in England and Wales*. Office for National Statistics.

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