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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.**

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.

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)

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.

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.'*

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.

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

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.

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.

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.

| 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.<br><br>Inter-agency partnership or network established to address needs of women with severe and complex PD.<br><br>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:<br>• mental health services<br>• psychological therapies<br>• substance misuse services<br>• offender health and rehabilitation services<br>• women's mental health<br>• primary care services<br>• CAMHS<br>• 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.<br><br>Early identification of people with PD through improved access to psychological therapies.<br><br>Comprehensive offender health and prison in-reach services that effectively address complex need profiles.<br><br>Informed links between social inclusion initiatives and PD programmes. |

| 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:<br>• flexible and appropriate access<br>• engagement<br>• case management/CPA<br>• advice and information<br>• assessment<br>• one-to-one interventions and therapy<br>• group interventions and therapy<br>• crisis management and support<br>• support into recovery<br>• peer group support.<br>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.<br>Improved mental well-being.<br>Increase in numbers of clients in settled and stable lifestyles.<br>Reduced use of emergency services, A&E and psychiatric in-patient care.<br>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.<br>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.<br>Also, for **future direction of travel**, the gradual development of:<br>• **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<br>• **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.<br>Reduced risk to public. |

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

| Population/severity | Criteria | Services required |
|---|---|---|
| **'High-harm-to-others' PD, including dangerous and severe PD**<br><br>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)**<br><br>• High PCL-R[33] score:<br>– Women 25+<br>– Men 30+<br><br>*Or*<br><br>• High PCL-R score + PDs:<br>– Women 18–24 + 2 or more PDs other than ASPD<br>– Men 25–29 + 1 or more PDs other than ASPD<br><br>*Or*<br><br>• Multiple PDs:<br>– Women: at least 3<br>– Men: 2 or more<br><br>*Criteria for referral to Tier 6 services*<br><br>• Likelihood of committing serious physical or psychological harm to others<br><br>• Identifiable severe PD as above<br><br>• Evidential link between PD and offending | Tier 5 dedicated PD secure services and comprehensive, lifelong community management<br><br>Tier 6 DSPD treatment units in NHS high secure hospitals and prisons<br><br>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

| 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.<br><br>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.<br><br>*Or*<br><br>• 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.<br><br>*Or*<br><br>• 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.<br><br>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.<br><br>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.<br><br>*Or*<br><br>• 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.<br><br>The Corston Report[34] indicates that on discharge from prison the most pressing need is accommodation. | • Residential treatment with a rehabilitative focus<br><br>*Or*<br><br>• HSTCRS-type service.<br><br>*Or*<br><br>• Long-term structured hostel or managed accommodation placement, and intensive community-based treatment.<br><br>Assessment and preparation could start within the prison setting through collaboration between prison staff and PD services. |

[34] Home Office (2007)

| 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.<br><br>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.<br><br>Additional service elements might include:<br><br>• NHS acute care: suitable staffed beds in admission wards, and other options<br><br>• occasional and planned access to short-term beds in NHS hospitals<br><br>• high-staffed or suitably structured residential accommodation (possibly in the voluntary sector)<br><br>• social care crisis facilities<br><br>• access to 24/7 support.<br><br>Case co-ordination management is carried out by PD Tier 3 service and becomes a crucial element.<br><br>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.<br><br>Dedicated pooled budgets would facilitate this.<br><br>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:<br><br>• are at high risk of suicide<br><br>• have very unstable lifestyles<br><br>• have a history of unstable accommodation or homelessness (in addition to clear treatment needs and suitability)<br><br>• cannot be managed in Tier 3 services or by enhanced Tier 3 packages.<br><br>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).<br><br>Should be able to address severe substance misuse as part of complex need.<br><br>To ensure effectiveness, services should work closely with local PD case co-ordination services. | Lead PCT or specialised commissioning group (SCG) commissioning. |

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.

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.

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.

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.

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.

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