Personality Disorder Pathway Strategy for the Yorkshire and Humber Region:

Making Connections and Delivering Community to Community Pathways.

Part 1 :
Methodology and Recommendations

Contents

It is acknowledged there are particular concerns with regard to the label 'personality disorder', with many service users, and clinicians unhappy with both the term and implications of the term. For the purposes of this Personality Disorder Pathway Strategy, given that it is an NHS England commissioned report, it is felt necessary to retain the label in accordance with the Specialised Commissioning manual of services. This report will use the term *"Individuals with a diagnosis of personality disorder"* or the wider terms *"service users"* where appropriate. A full description of issues is provided in the consensus statement on personality disorder available here: https://www.mind.org.uk/media/21163353/consensus-statement-final.pdf

The Project Lead for the Personality Disorder Pathway Strategy would like to give his sincere thanks to all the many service users and staff members from Cheswold Park, Garrow House, Humber Centre, Stockton Hall and Waterloo Manor who gave up their time and energy in contributing to this strategy. Their experiences and views have been greatly appreciated and have proved extremely helpful. Finally a special thank you to Holly Cade, Jo Harris, Viktorija Ozogova and Ged McCann who contributed a great deal to the planning and findings of this strategy.

Mark Naylor, Project Lead

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Introduction

The Personality Disorder Pathway Strategy for the Yorkshire and Humber Region: Making Connections and Delivering Community to Community acknowledges the historical challenges and changes to service culture and practice over the last twenty years or so when working with individuals with complex mental health problems that have a diagnosis of personality disorder. This includes developing a more informed understanding of personality disorder and the challenges faced by individuals in their everyday lives including impact on services. Positively, the development of legislation, national guidance and pathways has influenced the growth of personality disorder specific services and therefore an increased availability of psychologically informed interventions in particular.

However, services which should work closely with individuals in a clinically coherent way, and which recognise the significant impact of trauma, often understandably struggle to fully assess and meet the needs of individuals in a meaningful and beneficial way. Therefore services and service users continue to face significant challenges.

The *Personality Disorder Pathway Strategy* strongly emphasises the development of secure pathways which must include a 'community to community' approach. This includes prioritising the progression and integration of responsive community services into the overall pathway. Therefore the development of community services remains of paramount importance both in pathways prior to and after any hospital admission. A return pathway journey to the community must be a key task of all service provision. This will only be viable by the creation of safe, effective and quality focussed interventions delivered within a 'whole systems' pathway approach.

In completing this *Personality Disorder Pathway Strategy* it has been heartening to evidence that service user experience, research evidence, evaluation of personality disorder specific services, and development of effective pathways all have some level of agreement on what constitutes best practice and pathways. It is time for this key evidence to be consistently implemented by services.

It is hoped that this *Personality Disorder Pathway Strategy* provides the basis and momentum for the development of the required practice, culture and approach based on this key evidence:

- Acknowledgement of the impact of trauma.
- Primary importance of relationships.
- Service culture based on values and principles.
- Framework providing service user collaboration and partnership.
- Skilled and competent workforce with effective leadership.
- Range of available psychologically informed intervention
- Creation of integrated and responsive pathways connected to individual need.
- Best practice standards implemented within a cohesive framework.
- Need for evaluation and outcomes of interventions.

Finally, the *Personality Disorder Pathway Strategy* report cannot hope to solve all the challenges faced by individuals and services. However, the *Personality Disorder Pathway Strategy* has the opportunity to be the conduit for the creation of comprehensive, co-ordinated and connected spectrum of services within a *'community to community'* pathway approach. This will enable significant changes to the regional strategic direction regarding personality disorder practice and provision, which will also positively influence the everyday experience of all service users and staff members receiving and delivering care and treatment wherever they may be located. It is therefore essential all within services recognise with clarity and courage the need for the positive systemic change in culture and practice that is required for this strategy to be effectively implemented.

Personality Disorder Pathway Strategy Vision

The strategic vision of the *Personality Disorder Pathway Strategy* is the creation of *comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway* which are sensitive to the gender specific needs of all individuals. This includes an appropriately commissioned and resourced tiered pathway approach with the support of a clinical communities network which helps shape and share practice. All pathways and service interventions should be planned and delivered within a principles based framework which is consistently applied by all stakeholders across the pathway.

All individuals should have access to a competent, capable and consistently available care co-ordinator who is central to the collaborative planning of care and pathways wherever the individual is at the time. For consistencies sake, the oversight and enabling of this *'whole system'* personality disorder pathway should be provided by a dedicated service.

All services and interventions must be delivered within an *enabling environment which is psychologically and trauma informed* held and developed within a fit for purpose Clinical Model driven by best practice quality standards. This aspiration includes all secure services, whatever their diagnostic specialism, providing a range of safe, effective and quality focussed care and treatment interventions. Collaborative formulation and robust assessment of need matched by the required psychologically informed interventions which are delivered by a relationally focused workforce must be at the heart of service delivery.

This approach begins to moves away from the potentially reductionist debate of personality disorder specific secure services or not, toward a consistently applied service provision which meets the clinical needs of individuals across the secure services pathway, who may or not have a diagnosis of personality disorder, but who are likely to have the commonality of unresolved traumatic experiences and highly complex needs.

To achieve this vision, there must be meaningful engagement and collaboration with service users at all levels of service planning and delivery and the development of a highly skilled, resilient and supported workforce who are organisationally and clinically well-led and resourced.

Section 1: The Personality Disorder Pathway Strategy

1.0 Key Strategic Aims and Outcomes

The *Personality Disorder Pathway Strategy for the Yorkshire and Humber Region: Making Connections and Delivering Community to Community Pathways* is sponsored by and accountable to NHS England. The strategy hopes to develop and advance the strategic thinking for personality disorder services within the Yorkshire and Humber region from both a hospital and community based perspective.

A key aim of the strategy has been to develop meaningful and purposeful engagement with service users and the workforce within personality disorder specific secure services. This inclusive methodological approach has enabled an informed understanding of a range of experiences and views. In turn this enabled a collaborative vision for future service provision which hopefully assists the development of a strategic plan for how local mental health systems meet complex needs as well as key national and regional objectives.

The Personality Disorder Pathway Strategy aims to achieve the following key outcomes:

- Provide recommendations on how the Adult Secure Mental Health Service Review (MHSR) objectives are met through the development of current resources.
- Develop an informed understanding of current personality disorder specific secure services and provision across the region with a focus on service user and staff experience, outcomes, service models, gaps in provision, and the required therapeutic focus.
- Identification of future preferred pathways which encompass an understanding of an individual's journey from various hospital and community based services.
- Review development of required service and workforce capabilities and competencies when delivering effective personality disorder specific secure service pathways.
- Advise on proposed commissioning arrangements to enable recommendations of the strategy report to be effectively implemented.

The *Personality Disorder Pathway Strategy* has been planned, and had its progress monitored, by the *Personality Disorder Strategy Steering Group* consisting of several colleagues representing NHS England, a local Clinical Commissioning Group (CCG), Third sector housing and the regional involvement leads. The *Personality Disorder Strategy Steering Group* has not included specific professional clinical input given a key task of the strategy was to engage with various senior clinical and operational colleagues. It was agreed specific professional input may potentially prejudice the planning and development of the strategy. The group met regularly during development of the strategy.

Section 2: The Personality Disorder Pathway Strategy Approach

The original plan for the completion of the *Personality Disorder Pathway Strategy* included a review of each *Sustainability and Transformation Partnership (STP)* area (West Yorkshire and Harrogate, South Yorkshire and Bassetlaw and Humber Coast and Vale) using the same methodology with a plan to collate overall findings and identify recommendations. Unfortunately this could not be achieved due to resource demands including availability of project finances. An initial review of Humber Coast and Vale was completed in June 2018 with a shortened review of secure services within West Yorkshire and Harrogate and South Yorkshire and Bassetlaw.

The *Personality Disorder Pathway Strategy* approach was completed within the context of the principles of collaboration and engagement. This included listening, hearing and acting on the views and experiences of those living and working within personality disorder specific services. It involved completion of the following elements in order to meet its key aims:

2.0 Staff and Service User Focus Groups

Crucial to the success of the *Personality Disorder Pathway Strategy* has been the process of engagement and consultation completed with key stakeholders including service users and staff members within secure services. This has been achieved in order to gain an understanding of the views and needs of the various stakeholders.

This methodological approach included identification of main themes to be discussed with service users and staff members. The focus groups were separate for service users and staff members to enable everyone to feel comfortable speaking openly within the group. In general, staff members were happy to attend focus groups whilst the majority of service users preferred to attend meetings on a 1:1 basis. Staff members unable to attend focus groups were encouraged to complete a Survey Monkey Questionnaire. Paper copies were also sent to services so that service users could be involved.

Personality disorder specific services included those located within the three regional *STP* areas were part of the process (including Garrow House, Stockton Hall Hospital and Humber Centre within Humber Coast and Vale; Waterloo Manor within West Yorkshire and Harrogate; Cheswold Park Hospital within South Yorkshire and Bassetlaw). Cygnet Sheffield low secure services for women were not included due to cost pressures within the overall project.

The project was registered as a service evaluation by Leeds and York Partnership and Foundation Trust (LYPFT) Research and Development Department and has been reported on via the LYPFT 'Innovation' publication.

The findings from the focus groups were contained within the *Personality Disorder Strategy Report: Staff and Service User Focus Groups* completed in March 2019 by Holly Cade and Jo Harris, Yorkshire and Humber Regional Involvement leads.

2.1 Gathering the Views of Clinical and Operational Leaders

This approach built on the engagement with service users and staff members. The Personality Disorder Pathway Strategy Lead (Project Lead) met with clinical and operational Leaders from secure

services and Third sector organisations within the region. Several Consultant Psychiatrists/Responsible Clinicians were met with as well as significant representation from psychology, nursing and occupational therapy colleagues and senior operational leaders/service managers. The meetings were held either individually, in pairs, or in small groups and included attendance at clinical governance forums.

Subsequent discussions focused on pathways into and out of the service, individual need and service provision (delivery and evaluation). There was a focus on needs of staff members and development of overall pathways and relationships between secure and community services; what is currently in place and what could be further developed.

This methodological approach enabled the identification of a significant amount of information regarding the positive benefits and challenges of delivering personality disorder services.

2.2 Thematic Analysis and the Pathway Development Service

The Pathway Development Service (PDS) is commissioned as a national Personality Disorder Tier 4 Service to work across Yorkshire and Humber region and increase capacity and responsivity for working with personality disorder. The PDS has been uniquely placed to be part of the development of personality disorder specific services within the region and are able to objectively view the challenges faced by all stakeholders.

A thematic analysis methodology was used to identify and analyse and themes within a focus group setting. Seven health professionals employed by the PDS took part in the focus group. The project was registered as a service evaluation by LYPFT Research and Development Department. The report titled *Thematic Analysis of the Development of Community to Community Pathways for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder (2019)* by the Project Lead and Viktorija Ozogova, Assistant Psychologist presents the findings.

2.3 Service Evaluations

Rose ward was located at Clifton House Hospital in York bas part of LYPFT and commissioned by NHS England opening in early 2014. A key task was to deliver an alternative service for women at risk of entering personality disorder specific low secure services either at a distance from their home area or outside of the region and to repatriate those women within out of region placements.

A strategic aim was to work collaboratively with the PDS and Garrow house to form an effective care pathway for women. At the time of the closure of Rose ward in December 2017, the PDS offered a review of all women referred for an Access assessment to low secure services. This was to better manage the secure pathway for women and offer potential alternatives to admission. Garrow House worked closely with the women and the clinical team within Rose Ward to initiate early engagement and identification of potential discharge pathways to Garrow House.

Unfortunately, Rose ward closed due to a variety of factors which emphasised the difficulties in providing personality disorder specific secure services. The *Review of Therapeutic Security and the Practice of Safe Care and Treatment within Rose Ward* completed by Mark Naylor in April 2016 provided a review of the service and offered an analysis of challenges facing personality disorder

specific low secure services. The closure of Rose Ward was a damaging blow to the development of an effective regional personality disorder pathway approach for women.

It therefore seemed important to review key information from the referrals and admissions data to better understand the needs, impact and the gaps in pathway provision from opening to closure. Subsequently, the *Review of Low Secure Access Assessments and Referrals to Rose Ward* report was completed by Mark Naylor, Project Lead and Viktorija Ozogova, Assistant Psychologist as part of the *Personality Disorder Pathway Strategy*.

Two further service evaluations of (i) Swale Ward at the Humber Centre and (ii) Garrow House were also recommended as part of the initial Humber Coast and Vale review of personality disorder specific secure services. The service evaluations included the identification of key demographics, clinical factors, pathways and outcome datasets relating to individuals admitted to both services.

(i) Swale ward currently provides medium secure personality disorder specific services for men at the Humber Centre. It is a service that has been established for nearly ten years and originally opened to repatriate men to an NHS provision who resided within independent sector provision. The service was configured to develop pathways for men out of the Criminal Justice System (CJS). NHS England have directed Swale ward be reconfigure to a low secure service and medium secure services to be provided by Stockton Hall Hospital. Subsequently, Swale ward will provide personality disorder specific low secure services for men from the Humber Coast and Vale area with a reduced bed base. A service evaluation was requested to review and inform future strategic direction of the service and the overall pathway for men with a diagnosis of personality disorder. Subsequently the *Summary of Admissions for Swale Ward 2010-2018* report was completed by Carolyn Scott, Forensic Psychologist in conjunction with Rachel Dobbs, Ward Manager in May 2019.

(ii) Garrow House was initially commissioned by NHS England in 2009 as a high support 'step-down' service for women leaving secure services with complex needs although not exclusively a diagnosis of personality disorder. The service was initially part of a national Department of Health pilot scheme and developed through strategic partnerships between commissioners and providers. A key service aim was to enhance the care pathway for women in secure services. In April 2015, following 12 months of preparatory work alongside the PDS, Garrow House transitioned to a national Personality Disorder Tier 4 service. The Personality Disorder Tier 4 NHS England specification requires Garrow House not only provide inpatient services, but work closely with the PDS to ensure an integrated care pathway in line with the national Tier 4 specification. The *Garrow House: Review of Admissions 2009-18* was completed by Ranil Tan, Consultant Clinical Psychologist and Rose Stratton, Assistant Psychologist and had a similar scope to the service review completed by Swale ward.

2.4 Scoping of Service Provision

The *Personality Disorder and Complex Needs: Female Therapeutic Community Housing Provision with an Integrated Transition and Move on Service* was completed by Caroline Burnley, Community Links

Personality Disorder and Offender Services Manager in May 2018 as part of the *Personality Disorder Pathway Strategy*. This report encompassed a brief proposal of therapeutic community type provision for women as follow-on from hospital admission. A further *Residential Provision-Male Step Down* report was also completed by Caroline Burnley in March 2019 and described the challenges of men in secure services accessing appropriate step-down facilities. Both reports have helped developed thinking regarding future service provision for men and women within the region.

2.5 Literature Review

An initial search of the literature identified, despite the growth of personality disorder specific services throughout the UK within recent years, individuals still face barriers to access appropriate services. Few studies have been completed that looked at the full range of difficulties individuals face from referral, access, admission and discharge into and out of various services. A more in-depth appraisal of the literature was required and *Personality Disorder Service Provision and Challenges to Progressing Pathways and Management of Personality Disorder Services* was completed by Mark Naylor, Project Lead and Viktorija Ozogova, Assistant Psychologist. Key aims of the literature review was to analyse the existing guidance and policy on best practice interventions, service development and difficulties individuals with a diagnosis of personality disorder experience when transitioning between secure services and the community.

2.6 Involvement Events

Involvement events for service users and staff members living and working in personality disorder specific secure services were held on three occasions during the development and completion of *Personality Disorder Pathway Strategy* process. One event was held at the beginning of the strategy to enable some consultation regarding the implementation plan; a second one in the middle of the process to update on progress and a final event toward the end of the strategy in order to consult with stakeholders on key recommendations. This collaborative working enabled sharing of learning and experiences as the strategy developed and continued the involvement of stakeholders throughout the process.

Section 3: Developing a Shared Understanding of Personality Disorder

3.0 What is personality?

Personality can be described as a collection and pattern of relatively permanent traits and unique characteristics that give both consistency and individuality to a person's behaviour. Most definitions of personality focus on such patterns and characteristics that can help predict and explain an individual's behaviour. Personality affects thinking, feelings and behaviour, where and with whom the individual is with, in any situation at any time. Personality helps an individual to adjust and survive and deal with life's challenges including the development of stable relationships which satisfy them and others.

3.1 What is personality disorder?

There remains controversy over the conceptualisation of personality disorder, definitions and language used by professionals in particular. A diagnostic label should be helpful because it can act as a gateway for individuals to access the support and services they require. However, it is often experienced by individuals as a reason for professionals to deny access to services and the triggering of negative professional attitudes and responses.

*The Consensus Statement for People with Complex Mental Health Difficulties who are Diagnosed with a Personality Disorder (*Mind *et al, 2018)* described that the term 'personality disorder' should be abandoned entirely given *"the label is controversial for good reasons: it is misleading, stigmatizing and masks the nature of the problem it is supported to address, adding to the challenges which people experience".* However it is widely acknowledged that the term is used to allocate services and resources within the health and wider care system, and therefore a pragmatic response may indicate the necessity to continue to use the current diagnostic frameworks until something else is established.

Personality is usually defined in classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), and the International Classification of Diseases (ICD) as follows:

- An enduring pattern of emotional and cognitive difficulties which affect the way in which the person relates to others or understands themselves.
- This pattern of behaviour is pervasive and occurs across a broad range of social and personal situations.
- May lead to significant problems in occupational and social performance.
- Is not attributable to another mental disorder, substance abuse or head trauma.

A simple definition of personality disorder can be summarised as the ***Three Ps*** and the need for personality disorder to be **P**roblematic, **P**ersistent and **P**ervasive as described in the *Working with Offenders with Personality Disorder: A Practitioner's Guide* (2015):

Problematic For personality disorder to be present, the individual's personality characteristics need to be outside the norm for the society in which they live; that is they are; abnormal; and these characteristics cause difficulties for themselves or others.

Persistent Personality disorders are chronic conditions, meaning that the symptoms usually emerge in adolescence or early adulthood, are inflexible and relatively stable and persist into later life.

Pervasive They result in distress or impaired functioning in a number of different personal and social contexts: such as intimate, family and social relationships, employment and offending behaviour.

In summary, individuals differ in the ways that they view themselves and others, engage in relationships, and cope with adversity. It is quite common for these characteristics to occasionally interfere with an individual's ability to cope with life, and may also lead to difficulties in social interactions. When these difficulties are extreme and persistent, and when they lead to significant personal and/or social problems, they are more likely to be described as personality disorders.

3.2 How common is personality disorder?

Prevalence in the general population of personality disorder is estimated to be between 6-10% (*American Psychiatric Association, DSM-VI* 2013) although some estimates suggest that 1 in 16 people worldwide have at some point been given a diagnosis of personality disorder (Huang et al 2009). In specialised mental health care this figure rises to approximately 50% (Tyrer *et al,* 2015). Community studies of the prevalence of unspecified personality disorder report prevalence figures ranging from 10 to 13% (De Girolamo and Dotto, 2000). These studies have found that personality disorder are more common in younger age groups (particularly 25-44 year age group) and equally distributed between males and females. Estimates suggest personality disorder is prevalent in up to 52% of psychiatric out-patients (Keown *et al,* 2002) and in-patients (De Girolamo and Dotto, 2000). Personality disorder is particularly prevalent among in-patients with drug, alcohol, and eating disorders with prevalence figures reported to be in excess of 70% (Moran *et al* 2001). In the prison population, it is estimated that between 60 to 70% meet the diagnostic criteria of a personality disorder (Singleton *et al* 1998).

3.3 What is the impact of personality disorder on a person's mental health?

Individuals with a diagnosis of personality disorder are likely to have experienced extensive trauma, abuse and/or neglect in childhood and, in some instances, on into adulthood. Abuse may have been sexual, physical and/or emotional and have been perpetrated within the family, by another individual, or by an organised group. Attachment needs will not have been met and this may lead to serious issues around managing emotions and relationships in adulthood, deliberate self-harm, suicidal feelings and attempts, dissociation and a fragmented personality in some cases.

There is evidence of a causal and proportionate relationship between Adverse Childhood Experiences (ACE's) and poor physical and mental health with social difficulties in adult life (Filetti *et al*, 1998). A recent household survey of ACE's and their relationship with resilience to health-

harming behaviours in England described that 9% of the population reported experiencing 4 or more ACE's (Bellis *et al,* 2014).

There is evidence to suggest that a diagnosis of personality disorder is strongly associated with the diagnosis of other mental disorders including affective, anxiety and substance misuse disorders (Samuels, 2011). The presence of personality disorder can have an unfavourable impact on the outcome and responses regarding the treatment of such associated mental disorders (Tyrer *et al,* 2004), increases the risk of suicide (Moran *et al,* 2003) and compounds the risk of persistent substance misuse (Fenton *et al,* 2012).

Personality disorder is argued to be the most prevalent mental health disorder and therefore an associated and significant public health responsibility. However, there is little evidence to suggest that individuals are receiving the various interventions they need, or, indeed, that personality disorder occupies a proportionate place in public health service planning, appropriate to such responsibilities (Lamont and Brunero, 2009).

3.4 What is the impact of personality disorder on a person's safety?

Personality Disorder is associated with significant morbidity, including a high rate of deliberate self-harm and a significant risk of completed suicide within an individual's lifespan. It is estimated that up to 75% of individuals with a diagnosis of Borderline Personality Disorder (BPD) deliberately self-harm. Alongside this, it is also estimated that between 8% and 10% of individuals with a diagnosis of BPD will attempt to commit suicide at some point in their life and a figure of 5% is also estimated for individuals with a diagnosis of dissocial/antisocial personality disorder (Oldham, 2006).

3.5 What is the impact of personality disorder on a person's physical health?

Individuals with a diagnosis of personality disorder have a higher morbidity and mortality rate when compared to those without such a diagnosis. Both men and women with a diagnosis of personality disorder live considerably shortened lives: 18 years shorter for men and 19 years shorter for women (Fok *et al,* 2012). There appears to be both a higher incident of 'unnatural deaths' (suicide, homicide and accidents) as well as 'natural' causes of death such as respiratory disease and cardiovascular disease (Bjorkenstam *et al,* 2007). The high prevalence of smoking and substance misuse are also likely to be contributory factors influencing a person's health.

Difficulties and worries in developing and managing relationships with professionals and services may lead to problems in accessing appropriate help and support regarding any physical health concerns. Alternatively, studies have indicated that some individuals with a diagnosis of personality disorder are frequent users of health services at both primary and secondary care. In primary care, individual's with a diagnosis of personality disorder are more likely to be frequent attenders to general practice, medical and mental health services than those individuals without a diagnosis (Moran *et al,* 2001). Individuals may engage in difficult interpersonal behaviour with professionals which may lead to exclusion form such services (Hahn *et al*, 1996). This is compounded by the finding that compared to service users with psychosis; individuals with a diagnosis of personality disorder do not receive parity of health care (Sanatinia, *et al* 2015).

3.6 What difficulties may personality disorder contribute across the lifespan?

Lack of early interventions, including ongoing support and the delivery of psychologically based interventions, enable personality difficulties to continue throughout childhood into adulthood causing significant distress. From an early age, such individuals face increased risk of depression and suicidality, difficulties in psychological and social functioning, increased risk of substance misuse and contact with the criminal justice system, and lowered educational achievement leading to low paid employment or unemployment.

Individuals who later acquire a diagnosis of personality disorder due to the contributory factor of such experiences will continue to encounter multiple difficulties and challenges. This will encompass aspects of their physical, psychological and social functioning. Such difficulties are likely to be long term or even life-long, leading to a pattern of chronic and/or repeated cyclical contact with various services.

*The Consensus Statement for People with Complex Mental Health Difficulties who are Diagnosed with a Personality Disorder (*Mind *et al, 2018)* suggests that less is known about the lives of older age adults who are less likely to receive a diagnosis of personality disorder and who have limited contact with services compared to younger age groups. That is not to say that older age adults do not experience problematic persistent and pervasive difficulties in their day to day lives. Bereavement and loss are likely to be experienced by individuals in later life which has a significant impact on psychological and social functioning including loss of relationships that were supportive in helping the individual manage in their day to day life.

The impact on individuals as they reach older age including dementia, previous substance missus, excessive use of prescribed and non-prescribed medication combined with a diagnosis of personality disorder is largely unknown and therefore requires further understanding.

3.7 What is trauma?

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotion, or spiritual well-being (Proctor *et al,* 2017). Multiple definitions of trauma exist and may include interpersonal violence (e.g. sexual, physical or emotional abuse); neglect, loss and/or witnessing others experience these same traumas. For many individuals the experience of such events is usually repetitive, intentional, prolonged and severe, which means that the impact of trauma can be pervasive. Such traumatic events are associated with the development of Post-Traumatic Stress Disorder (NICE Guideline, 2018) and include a range of symptoms associated with functional impairment:

- Re-experiencing.
- Avoidance.
- Hyperarousal (including hypervigilance, anger and irritability).
- Negative alterations in mood and thinking.
- Emotional numbing.
- Dissociation.
- Emotional dysregulation.
- Interpersonal difficulties or problems in relationships.
- Negative self-perception (including feeling diminished, defeated or worthless).

Complex Post-Traumatic Stress Disorder develops within a subset of individuals with PTSD. The disorder is characterised by the core symptoms where traumatic events are experienced as multiple and/or prolonged. In addition to the above symptoms, complex PTSD is described as:

- Severe and pervasive problems in affect regulation.
- Persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event
- Persistent difficulties in sustaining relationships and in feeling close to others.

The distinction between the diagnosis of complex PTSD and that of BPD remains controversial due to obvious similarities in symptoms. Both can be seen to result from damage and disruption to the attachment system and all its manifestations and includes disturbance to the attachments that individuals develop with each other, in both family and community life (de Zulueta, 2006). However, the latter is often thought of as a stigmatising diagnosis that elicits a negative response from healthcare professionals (Nehls, 1998). In addition, the diagnosis of complex PTSD acknowledges the sexual abuse that many individuals with a diagnosis of BPD may have suffered.

3.8 What is Trauma-Informed Care?

There is developing recognition that experiences of trauma are common and a compelling body of evidence that demonstrates the increased risk of mental health problems associated with exposure to ACE's.

Within secure services there are several factors, including the physical, procedural and relational aspects of such environments, which can be re-traumatising for individuals. Staff members can inadvertently invalidate an individual's experiences and therefore reinforce maladaptive behaviours and coping skills within this situational context (Levenson, 2014). For example, it has been common practice to utilise seclusion, segregation and restraint as restrictive interventions to manage individuals who display behaviours associated with trauma, including distress and aggression. The use of such restrictive practices is likely to be re traumatising for the individual and staff members involved and likely to impact on the individual's willingness to engage and work collaboratively. This

effectively destabilises care and treatment including the therapeutic alliance between the individual and staff members (Wigham & Emerson, 2016).

There is a growing awareness services and professionals need to move away from traditional methods in the way individuals are offered care and treatment toward a trauma informed principles based approach. This approach offers a framework for delivering care and treatment based on an informed understanding of how trauma affects individual's lives, their needs and subsequent service delivery.

Adopting a trauma informed approach means designing and delivering services that are underpinned by what is known about trauma and its psychological impact including endeavouring to avoid re-traumatising individual's and staff members alike. The development of trauma informed services is not a treatment model per se but a cultural shift with a core principle of first 'Do no harm'. This approach raises awareness of trauma, emphasises safety, helps the individual rebuild control and is strengths based. Therefore it is described as a *"strengths based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety of both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (*Hopper *et al*, 2010).

3.9 What is helpful when working with personality disorder?

Adopting a trauma informed approach appears likely to be the key in better recognising, understanding and treating individuals with a diagnosis of personality disorder. It informs better organisation of services in the delivery of safe, effective and quality based psychologically informed interventions. This approach integrates the key principles of recovery (Hope, control, and opportunity) with specific trauma informed practice principles:

- Safety.
- Trustworthiness and transparency.
- Peer support.
- Collaboration and mutuality.
- Empowerment, voice, and choice.
- Cultural, historical and gender issues.

The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder (Mind et al, 2018) provides a helpful description of what individuals with a diagnosis of personality disorder may require when receiving services. This encompasses key principles expressed in previous personality disorder specific frameworks and guidance:

1. ***Shared ownership/collaborative:*** Services work mutually with the individual and enable effective communication both with the individual and between agencies.
2. ***Formulation/creative response/flexibly designed:*** Completion of a person centred, individualised trauma informed co-produced formulation.
3. ***Relational practice/connected:*** Staff members are supportive and understand that relationships are central to the individuals life and relationships with public services keeps them safe. Psychologically informed environments should be developed.
4. ***Sustainable long term planning:*** A right to access a lifelong service pathway including attention to psychological health and well-being: prevention and intervention across all public agencies.
5. ***Right treatment/right place/right time:*** A right to receive evidence based treatments that offer an integrated approach to care. Staff members supported by co-produced training and regular supervision with meaningful outcomes collated by services.
6. ***Supportive/competent/reflective staff:*** Competent and supportive staff members that are self-reflective, compassionate and supported within the service culture.
7. ***Culture change/changes to the label "personality disorder":*** A right to be treated with respect and offered appropriate interventions according to need rather than a diagnostic label.

Section 4: Key Principles

The *Personality Disorder Pathway Strategy* has been shaped by the need for adherence to key principles given the competing demands and expectations of the various stakeholders within the current pathway. Therefore it has taken a *'whole system'* pathway approach as the foundation on which a strategy can be developed.

The aim of a *'whole system'* pathway approach is the ability to assess a person's needs prior to contact with secure hospital services, and to provide a personality disorder specific response with multi-agency and multi-professional support throughout the person's pathway journey. Such providers will be expected to work in partnership to develop systems and multi-agency pathways.

This includes the aspiration and principle of a *'community to community'* pathway for all individuals with a diagnosis of personality disorder who are likely to/have been in contact with secure services.

The *'community to community'* approach is the application of a coordinated pathway across the variety of health, social care and third sector provision when working with people with a diagnosis of personality disorder. The 'community to community' approach recognises the various stages of an individual's journey from admission to secure hospital services to community based care and support. It is recognised that such individuals are likely to require a significant period of time in receipt of services until progress is made and evidenced.

By applying a *'whole system'* and *'community to community'* pathway approach the following is more likely to be provided on a needs-led and timely basis:

- Effective community pathways that offer alternatives to secure service admission and acute admission.
- Secure service pathways which provide therapeutic benefit and allow for timely discharge.
- Community pathways which provide the necessary care and support to assist individuals in remaining out of secure services.

This overall approach recognises and aims to navigate the various transitional stages of an individual's journey across a currently fragmented local and regional pathway. It also fits the overarching plan and requirements for the total population of Yorkshire and Humber over the next three to five years.

Section 5: Key Recommendations

The following 9 key recommendations form a significant part of the development of the *Personality Disorder Pathway Strategy* based on the findings of the strategy approach. The recommendations are divided into 4 sections:

- **Recommendations 1-4: Developing a comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway.**
  - A tiered pathway approach.
  - Clinical communities
  - Principles based framework
  - Development and oversight of the pathway.

- **Recommendation 5: Developing supportive interventions.**
  - Peer Support

- **Recommendations 6-7: Developing frameworks for delivering safe, effective and quality focussed interventions.**
  - Clinical Model
  - Best practice standards and audit criteria

- **Recommendations 8-9: Gender specific pathways and interventions for male and female pathways.**
  - Pathways for women
  - Pathways for men

Key Recommendation 1: *Pathways for individuals with a diagnosis of personality disorder are delivered within a tiered pathway approach which is developed by all stakeholders*

As long ago as 2009, the *Department of Health* *Recognising Complexity: Commissioning Guidance for Personality Disorder* established the importance of developing service provision within a 'whole system' approach in order to deliver the *creation of comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway.* This approach ensures effective and responsive pathways and avoids development of 'stand-alone' services.

The comprehensive functions of *a 'whole system'* service provision for individuals with a diagnosis of personality disorder are contained within a tiered pathway approach which also adheres to the *'community to community'* co-ordinated pathway approach. The tiered pathway provides a framework for services responding to different levels of complex need, with services available at local and regional level including personality disorder specific services. Services are responsive to severe need provided for in wider geographical areas and larger populations. Partnership between various statutory and independent providers is essential for the delivery of such services.

The following table describes the tiered pathway approach:

❖ **Tier 1 Consultation, Support and Education:** Ensure responsive mainstream services for individuals with a diagnosis of personality disorder including access to appropriate housing, employment, training etc. to support full recovery. Consultation and support provided to community agencies.
❖ **Tier 2 Community-based Treatment and Case Management:** Ensure appropriate assessment, treatment and case management in community and prison settings for individuals who do not pose serious risk to others.
❖ **Tier 3 Intensive Day Services, Crisis Support and Case Management:** To ensure appropriate assessment, treatment and case management for: • Individuals whose levels of risk to self and severity require more intensive community-based treatment. • Offenders with a diagnosis of personality disorder who present limited risk to others.
❖ **Tier 4 Specialist, Inpatient and Intensive Services**: Ensure appropriate assessment and treatment for diverse population groups with a diagnosis of severe and complex personality disorder, who may need treatment on a 24-hour basis. Individuals may include those who present a high risk of harm to self and some whose risk of harm to others has decreased so that they can 'step down' from more intensive and secure services.
❖ **Tier 5 Secure and Forensic Personality Disorder Services:** Ensure, across health services and the CJS, appropriate assessment and treatment at required levels of security. This includes longer-term rehabilitation and maintenance/monitoring for those with severe personality disorder who present a high risk of harm to others. Support from Multi Agency Public Protection Arrangements (MAPPA).
❖ **Tier 6 Dangerous and Severe Personality Disorder Units:** Ensure appropriate assessment and treatment at required levels of security who present the highest risk to others; and to ensure co-ordinated access to highly specialist facilities in the NHS and National Offender Management Services (NOMS).

Development of a tiered pathway approach relies on the commitment and the allocation of resources by CCG'S, NHS England and *Provider Collaboratives*. There is concern gaps remain in service provision especially at Tiers 1-3 for individuals with a diagnosis of personality disorder and that Tier 4 provision for women requires further development.

Finally, until pathways and services at Tiers 1-4 are further developed, women in particular will be at increased risk of entering hospital services and subsequently escalating to more restrictive environments. Without connected pathways between Tiers 1-3 and Tier 5, men will be more likely remain in secure services for long periods of time, partly due to a lack of appropriate discharge pathways including 'step-down' services. It important that the *Personality Disorder Pathway Strategy* actively supports the tiered pathway approach as a key contributing factor to the *creation of comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway.*

Key Recommendation 2: *The Personality Disorder Pathway Strategy is developed and delivered within a clinical communities network approach in collaboration with all stakeholders across the pathway with an enabling role provided by a dedicated service building on the work of the PDS.*

Gaps and a lack of consistency in therapeutic approaches are often found between how interventions should be delivered, as defined by high quality evidence and best practice, and the care and treatment that individuals with a diagnosis of personality disorder actually receive. Closing these practice gaps and promoting consistency of approach is an important priority for services and systems but finding the right structure to facilitate improvement is complex.

Clinical communities are a professionally-led, professionally-owned network that aims to enhance knowledge, promote ideas and harness collective and collaborative action toward common goals. The fundamental principles of a clinical communities network are professional leadership and inclusive membership. Members participate because they wish to make to make effective change happen and are united by common principles and purpose.

This approach enables all involved in personality disorder specific services to mobilise peer and service user experiences and influence changes to systemic and individual behaviour and practice. Members participate because they want to make effective change happen and are united by a common purpose of increasing the wellbeing of all individuals including the workforce. All members agree to work collaboratively and engage with everyone to deliver their shared goals.

Clinical communities may be based locally or regionally and should work closely with *Provider Collaboratives* in terms of influence and responsivity to the needs of all stakeholders. Therefore a clinical communities network approach has the ability to support and secure improvements in pathways and interventions across multiple sites. The structure of clinical communities is a simple one, compromising a core team that support teams in different sites/areas to make change happen locally. It is envisaged a dedicated service should take this enabling and leadership role building on the work of the PDS given its function to work with personality disorder across the region including acute mental health, community and secure service pathways.

The Health Foundation Using Clinical Communities to Improve Quality (2013) report describes 10 key lessons about when to use a clinical communities network, how the clinical communities approach should work in practice and how to avoid predictable difficulties:

1. Choose the right challenge for a clinical communities approach	Clinical communities are well suited to areas where problems to be tackled are addressed by changes to processes and behaviours rather than large scale re-design or where debates need to identify what 'good' looks like.
2. Build a strong core team	Clinical communities have at their heart a well-regarded, experienced core team to lead, motivate and organise the community.
3. Recruit a community	Clinical communities need to have boundaries porous enough to ensure inclusion of all relevant stakeholders, but tight enough to help them stay focused on clear goals.
4. Resource the community properly	Clinical communities cannot function on goodwill and intentions alone.
5. Start with a clear 'theory of change' but review and adapt in light of learning and experience	A clear theory of change that articulates the goals of the community and the how and why of their achievements is essential.
6. Foster a sense of community and belonging	Communities should choose achievable goals which unite members; each member is made to feel part of the solution and responsible for reaching the solution.
7. Recognise and deal with conflict and marginalisation	Clinical communities should deploy tactics for ensuring inclusion and to avoid creating situations that show up differences in status or performance.
8. Find a balance between 'hard' and 'soft' tactics	Clinical communities should use a mix of both 'soft' persuasion and appeals to professional goodwill, and 'harder', more directive methods to achieve their goals.
9. Use data wisely	Data collection, evaluation and feedback, throughout and beyond the lifetime of a project, are central to all improvement efforts; if used effectively, it can make a compelling case for improvement.
10. Recognise the contextual influences on improvement and the need for customisation	Core teams need to work with members to generate bespoke solutions, without losing sight of their goals or shifting too far from what is likely to achieve change.

It is recommended each local *STP* area or region may initiate and recruit a fully focussed and resourced clinical communities network made up of all stakeholders. The initial challenge would be to develop a shared vision of clinical communities acting as a collaborative forum for identification of specific challenges and the changing of systemic and individual behaviours within the pathway via review of services and agreed future goals

Key Recommendation 3: *The Personality Disorder Pathway Strategy is planned and delivered within a principles based framework which is developed, shared and consistently applied by all stakeholders across the pathway and which is supported by a clinical communities network approach.*

The current system of services and pathways is complex and challenging to navigate for all stakeholders. A principle's based framework supports and enables a shared vision which applies to all stakeholders and services within a tiered pathway approach whether hospital or community based.

The following 12 principles are sourced from current best practice when working with personality disorder:

1. Shared values are in place across the pathway including a '*community to community'* approach and where services are developed within a tiered pathway approach.
2. Shared understanding that secure and non-secure hospital services have an important pathway role but for as short a time as required, in the least restrictive environment, and as close to home as possible with care co-ordination available and consistently applied.
3. Shared ownership, partnership and connection between all pathway stakeholders are enabled via a clinical communities approach in order to improve quality and outcomes.
4. Planning and delivery based on a '*whole system'* approach with acknowledgement that a minority of individuals are likely to require a relatively significant period of time over which progress is made.
5. Formulation leads to an improved understanding of the individual and behaviour, resulting in a pathway reflecting need and the required service and workforce response.
6. All assessment, treatment and management interventions are psychologically, socially and trauma informed and collaboratively planned and delivered.
7. Gender specific and culturally aware service design.
8. Pathway difficulties that may lead to more restrictive services and/or interventions are safely managed. Pathway plans are reviewed with continued attempts at engagement and progress. All individuals remain part a tiered pathway network approach.
9. Staff members require a shared psychologically and trauma informed approach held within an appropriate clinical model with opportunities for reflection and supervision.
10. Individuals with a diagnosis of personality disorder are co-producers of their care with opportunities for collaboration at all levels of individual and service intervention.
11. Individuals are clear about their own pathways including expected interventions and their roles and responsibilities.
12. All pathway services need agreed outcomes which are able to be evaluated.

A principle's based framework provides a framework for services and pathways to offer an *enabling environment which is psychologically and trauma informed.* Any principles based framework must seek to develop the culture and practice of all connected to the pathway by the *creation of*

comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway.

Finally, progression of a principles based framework is best developed, delivered and monitored via a clinical communities network approach which is consistently applied by all stakeholders. This enables a shared vision, an ethos of community collaboration and ability to solve pathway difficulties alongside all stakeholders. It is important stakeholders genuinely adhere to the principles based framework in order to deliver consistent and quality based interventions across the pathway which meet the aspirations contained within the framework.

Key Recommendation 4: *The creation of comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway will require effective oversight. This must be supported by the development of a tiered pathway and a clinical communities network approach which will require leadership and oversight by a dedicated service.*

A dedicated service to oversee the *creation of comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway* would work locally, or more optimally, across the region to increase capacity and responsivity in order to improve and develop pathways. This newly devised service would build on and develop the existing work of the PDS. This includes identifying and developing specific interventions and alternative pathways for individuals currently within various hospital services who are in danger of escalation into more restrictive and secure services.

The overall service aims would be to support the following:

- Enable effective development and oversight of the *'community to community'* pathway based on a tiered pathway approach attached to clinical communities and held in a principle's based framework.
- Expand collaboration and connections between all stakeholders within the pathway.
- Develop consistent application of best practice interventions.
- Develop and deliver interventions to meet the training needs of the workforce and enhance leadership.

These core functions will be provided within the context that decisions to admit individuals to acute mental health pathways is often reached due to an apparent lack of viable community options within local areas. Further escalation into locked rehabilitation and secure services may be averted if acute mental health pathway services (Tiers 1 to 3) are better able to meet initial needs for safety and containment as well as having opportunities to discharge to robust community services.

Evolution of the proposed service will attempt to support and follow individuals through a complex and fragmented system of services and pathways. The functions of the proposed service can be further established and expanded to enable more effective contribution to the *creation of comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway.*

Such aims are best achieved by the development of the core functions of the proposed service including the implementation of the following 10 point plan:

1. Collaborative working with clinical communities and develop interventions which connect the pathway with the needs of the individuals.
2. Reviews for all men and women referred to low and medium secure personality disorder specific services prior to completion of any Access assessment.
3. Reviews for all men and women within low and medium secure personality disorder specific services whose pathway out of services appears obstructed.
4. Re-review process to include:
   (i) Re-review men and women in personality disorder specific locked rehabilitation services.
   (ii) Re-review individuals when discharged to the community. Re-reviews would occur via the CPA process.
5. Development and support of case formulation which is regularly reviewed as part of the re-review process.
6. Consultation offer to care coordinators when a review has taken place and/or when discharge planning commences from any hospital service.
7. Development of specialist and bespoke training co-designed and delivered with service users.
8. Enhancement of the Housing and Resettlement role that commences on admission and continues toward transition and discharge.
9. Advancement of best practice standards within the pathway including practical help and advice in the implementation and review of standards within services.
10. Planning, implementation and review of a range of specific interventions to support and develop services.

Recommendation 5: *Introduction of peer support for women by the development of Peer Support Workers which enables and supports women to navigate through the 'community to community' pathway.*

Peer support is based on the relationships that individuals build as they share their own experiences to help and support each other. Peer support can develop in any setting with as much structure as is beneficial to the process. Often individuals with a diagnosis of personality disorder, particularly within secure services, may lose hope about their personal recovery and find difficulties in engaging with services which they may not trust and where they feel unsafe. This is particularly pertinent for women given the gender specific difficulties when entering hospital services. The benefits of receiving peer support should be recognised as a positive therapeutic intervention for women especially when it is peer support from women with their own experiences of services.

The *Together for Mental Wellbeing Peer Support in Secure Services: Final Report* (2017) describes the benefits and value of peer support:

- Increased wellbeing and greater rates of recovery.
- A sense of self-esteem, independence, equality, mutuality and empowerment.
- Acceptance, solidarity, empathy and understanding.
- Companionship and improved social functioning.
- Reducing stigma and isolation.
- Hopefulness; a focus on strengths and potential.
- Reduced reliance on services.

Future peer support for women with a diagnosis of personality disorder is recommended via the introduction of a small number of female Peer Support Workers working with women currently within hospital services and who continue to support them across the pathway whether in community or secure services for an agreed period of time.

It is proposed that Peer Support Workers would have the following key tasks to complete:

- Work across a specific local area and support women across the pathway offering a *'community to community'* approach.
- Offer a formal and specific role to women on a one to one basis.
- Provide choice and control for women in how they participate in peer support.
- Actively acknowledge a connection with service users based on having gender and service specific experiences in common.
- Develop relationships that are two-way, and involve both giving and receiving support.
- Provide support that is able to be increased at times of crisis and transition.
- Develop capacity and sustainability by building skills, knowledge and support requirements.
- Develop structures to provide physical and emotional safety for all.
- Access readily available supervision and reflective practice opportunities.
- Build on the evidence base for the effectiveness of peer support.
- Connect with the principles based framework and clinical communities approach.

The nature of peer support and its recent history of being developed by Third sector services suggest future service provision is provided by a strategic partner able to work within a local area which has a previous history of development of such services for women. Any provider would work closely with the suggested pathway service described in the previous recommendation which may be able to offer opportunities for supervision and reflection for Peer Support Workers.

Key Recommendation 6: *The planning, implementation, monitoring and evaluation of a fit for purpose Clinical Model when providing personality disorder specific services must be a prerequisite of such services.*

A Clinical Model aims to provide the central conduit for planning, implementation and evaluation of care and treatment interventions within a service and its connection to all stakeholders. It describes the optimum service interventions required within the context of delivering best practice interventions including delivery within a *'community to community'* approach. There should be an expectation that all individuals with a diagnosis of personality disorder receive the right care, delivered by the right people, doing the right things, in the right order, at the right time, in the right place, with the right outcome.

A Clinical Model aims to meet the needs of individuals and the workforce and encompasses the following 6 key components:

1. **Values and principles framework:** Contains and promotes a key set of values and principles held by all stakeholders in its relational functioning and clinical practice. Values and principles are held and shared by individuals with a diagnosis of personality disorder so all are held account for their development and application.
2. **Five stages of the treatment process**: Offers a broad conceptualisation of 'treatment' via a 5 staged approach which informs the phases of delivering treatment.
3. **Key standard practice domains:** All care and treatment interventions take place in 4 standard practice domains integrated within the 5 staged approaches: Assessment, Formulation, Therapeutic Interventions and Culture. All interventions contained within the practice domains are applied to each phase of the treatment process.
4. **Integrated care pathways:** Delivers a system for developing care pathways which are formulation informed and developed within a culture which promotes involvement and development.
5. **Best practice quality standards and audit criteria:** An attempt to shape and inform the content of pathways within the 4 key practice domains. The minimum standards of care and treatment interventions to be provided.
6. **Outcome measures and evaluation:** Development of clinical, social and quality of life outcome measures which evaluate the effectiveness of interventions including the Clinical Model approach.

The development of a Clinical Model matches 5 key themes that appear repeatedly within national policy related to mental health quality provision:

- **Service user focus** - How services users are present, powerful and involved within services and how their needs form the basis of all interventions.
- **Information focus** - How information is assessed, collected and used in an evident and transparent way.
- **Quality improvement** - How standards are safe and do no harm, experience of care is characterised by compassion, dignity and respect and effectiveness of care helps recovery and enhances quality of life.
- **Staff focus** - How staff members are supported and developed and where healthy environments are created which improve well-being for all**.**
- **Leadership** - How leaders at all levels deliver safe, effective and quality focussed care and treatment.

It is recommended that a fit for purpose Clinical Model implemented throughout secure services working with individuals with a diagnosis of personality disorder is best planned and evaluated via the clinical communities network approach. This would enable consistent best practice interventions via an agreed framework to be shared and applied throughout secure service pathways which is likely to enable beneficial outcomes for all stakeholders.

Key Recommendation 7: *Implementation of best practice quality standards and audit criteria within an existing secure service is recommended as part of an evaluation project. This will inform the development of standards as well as providing an opportunity to improve clinical interventions and contribute specifically to the design of Clinical Models.*

Best practice quality standards and audit criteria were initially developed by the PDS and more recently as part of a dedicated work stream related to the *Personality Disorder Pathway Strategy*. The primary task of the standards and audit criteria is to offer a framework for positively changing practice within personality disorder specific services. The standards are not intended to be used as a definitive list that is required to be completed as a routine checklist but rather a meaningful best practice framework of interventions which is integrated within a fit for purpose Clinical Model. The standards must be fully embedded within the Clinical Model and applied across services.

The development of the standards consists of the following 5 key areas:

1. ***Best practice values and key principles*:** 8 key principles within the context of values based practice and care.
2. ***Best practice standard domains:*** 4 practice domains of Assessment, Formulation, Therapeutic Interventions and Culture.
3. ***Best practice quality standards:*** 11 core quality standards aligned to the 4 practice domains.
4. ***Best practice audit criteria*:** Connected to the 4 practice domains. There are 92 best practice audit criteria required to meet the overall 11 quality standards criteria.
5. ***Best practice audit criteria data collection tool*:** Provides evidence of whether the 92 best practice audit criteria are met by services.

Best practice quality standards contained within a Clinical Model provides the foundation for personality disorder specific services to better assess, formulate, plan, implement and evaluate a range of psychologically informed interventions. It is recommended an initial evaluation of the implementation of the best practice standards and audit criteria is completed within an existing personality disorder specific service. The standards can also apply to any service working with individuals with a diagnosis of personality disorder.

Key Recommendation 8a: *Further development of a 'community to community' pathway for women to include the development of secure services and Tiers 1-4 pathways. Services must provide an enabling environment which is psychologically and trauma informed.*

There is a range of secure service provision available for women with a diagnosis of personality disorder within the Yorkshire and Humber region. However, no *Provider Collaborative* has a fully informed secure service pathway for women and their remains variable community based resources for women across the region. It is also a matter of concern that a significant number of women are placed in out of area locked rehabilitation services with no national specification often as an alternative to Personality Disorder Tier 4 provision.

The gaps in current secure service provision for women include:

- No current personality disorder specific medium secure services within West Yorkshire and Harrogate.
- No current personality disorder specific low secure services within Humber Coast and Vale.
- No personality disorder specific medium secure services within South Yorkshire and Bassetlaw (although may be resolved by the planned provision of 'hybrid' medium and low secure services).
- Lack of 'step-down' services for women leaving secure services other than Garrow House.
- Lack of Personality Disorder Tier 4 services for women other than at Garrow House.
- Lack of consistent and fully resourced Tiers 1-3 pathways within most local areas across the region.

It is important the complex needs of women with a diagnosis of personality disorder due to be repatriated to secure services within their local *STP* area are fully assessed and understood. This will identify the requirement for continuing placement in secure services at the current level of security and/or whether future needs could be met within existing mental illness specific services. This approach toward a more generic service provision aims to provide equitable access for all women to an *enabling environment which is psychologically and trauma informed.* It is envisaged such environments will be more likely to meet the needs of some women currently within personality disorder specific services who have been the victim of significant abuse and resulting trauma in particular. This approach may result in significant cost savings which could help develop a range of community provision for women including 'step-down' services.

Alongside the development of secure services to meet the needs of women with a diagnosis of personality disorder, development of a tiered pathway approach (including Tiers 1-3 and the progression of Personality Disorder Tier 4 services) is crucial to help provide the *creation of comprehensive, co-ordinated and connected spectrum of services within a 'community to community' pathway.* This pathway approach lessens the likelihood of women entering secure and other hospital based services and enables more timely discharge from all types of hospital provision.

There remain a number of issues that need further discussion, clarification and agreement from local *Provider Collaboratives* within the existing women's personality disorder specific pathway and which form further sub recommendations:

Recommendation 8b: *The current role and function of Garrow House as a combined 'step-down' and Tier 4 service should continue until such time there is clarification regarding proposed Tier 4 provision and development of high support 'step-down' services.*

Garrow House remains a regional service commissioned by NHS England for women with a diagnosis of personality disorder. It provides a Personality Disorder Tier 4 service in partnership with the PDS. Garrow House also remains a 'step-down' service for women in secure services that have a diagnosis of personality disorder and provides a 'step-across' service for women previously residing within independent locked rehabilitation services.

As previously described a service evaluation was completed as part of the *Personality Disorder Pathway Strategy.* Any decisions regarding future role and function of Garrow House should be informed by the findings of the service evaluation. This includes the continued need for Personality Disorder Tier 4 provision to work closely with more widely developed Tiers 1-3 pathways and for 'step-down' services within the region to offer a realistic discharge pathways for women in secure services

The service evaluation would suggest the number of admissions evidence the need for Garrow House to continue to currently provide both at a Personality Disorder Tier 4 and high support 'step-down' service. Women originating from West Yorkshire and Harrogate and Humber Coast and Vale in particular have been regularly admitted to Garrow House with the agreement of both CCG and NHS England commissioners. Any potential loss of access to such a service will influence the planning of future services for women especially within secure services for those two *Provider Collaboratives* given the potential gap in provision.

A number of questions remain from the service evaluation which will inform the future direction of services for women within the region which requires further discussion and an agreed way forward:

- Is Garrow House able to remain a combined service or focus on 'step down' or Personality Disorder Tier 4 specification exclusively?
- Is Garrow House able to provide a service for the whole Yorkshire and Humber region or for Humber Coast and Vale women only?
- If decisions are made which may potentially decrease the number of referrals and therefore admissions to the service (e.g. serving only Humber Coast and Vale, becoming either a Tier 4 or 'step-down' service) will the number of beds required need to be reviewed in light of such potential developments?

Recommendation 8c: *Further progression of a 'community to community' pathway for women by developing residential services aligned to existing 'step-down' secure services and Personality Disorder Tier 4 provision.*

Future community service provision proposed for women has been completed as part of the *Personality Disorder Pathway Strategy* by Caroline Burnley, Community Links Personality Disorder and Offender Services Manager. The proposal includes supported residential living provision which at various stages of the pathway for women who require a safe therapeutic space with a focus on support and engagement within a community setting.

Given the significant number of women within the personality disorder pathway, both within the community and various hospital services, consideration should be given for an agreed model to be replicated and implemented within each local *STP* area. It would be best provided in partnership with a Third sector organisation which have expertise in providing residential and supportive day services that are gender specific to women.

Women referred to the service are likely to have a diagnosis of personality disorder but referrals would be accepted for those without such a diagnosis but who have a significant experience of trauma with the resulting impact on their personality functioning and safety in particular. Pathways into the service would be from the acute metal health, secure, locked rehabilitation and Tier 4 inpatient services.

This proposed supported residential living provision should provide a 'step-down' option with access to a package of therapeutic and housing support for a duration of two years within a 24 hour multi-disciplinary staffed environment but would not be a registered nursing home thus lowering the financial resources required. A residential therapeutic community framework should be employed which supports the creation of an *enabling environment which is psychologically and trauma informed.*

Pathway planning for transition, move on and after care would be integral to the service for duration of up to one year further to discharge from the service. This may be provided by a partnership between local community services and a Personality Disorder Tier 4 service providing community outreach as part of its specification until such a point arises when involvement can be transferred to local community services. The residential environment may be developed to support an optimum of 10 women at any given time.

Potential discharge pathways into independent community living with the appropriate level of support are a key task of the service. A robust Housing and Resettlement component would be required to support the transition and discharge pathway from admission.

Key Recommendation 9a: *Further development of a 'community to community' pathway for men with a diagnosis of personality disorder to include the development of secure services, 'step-down' pathways and Tiers 1-3. Services must provide an enabling environment which is psychologically and trauma informed.*

There is a range of low and medium secure services available for men with a diagnosis of personality disorder within the region but no current 'step-down' or Personality Disorder Tier 4 services. It is a matter of concern that a number of men are placed in out of area locked rehabilitation services often due to a lack of high support 'step-down' services. Locked rehabilitation services are likely to be used as a 'step down' option, often due to the lack of other less restrictive alternatives.

The gaps in current secure service provision for men include:

- No current personality disorder low and medium secure services within West Yorkshire and Harrogate.
- Lack of specific 'step-down' services for men leaving secure services.
- Lack of robust and fully resourced Tiers 1-4 pathways within most local areas.
- Prisons and secure services working collaboratively within the pathway.

It is therefore recommended that priority should be given to men within secure services to be repatriated to West Yorkshire and Harrogate in particular and it is important their complex needs are fully assessed and understood.

This will identify the requirement for continuing placement in secure services at the current level of security and/or whether future needs could be met within existing mental illness specific services. This approach matches that of women as described in *Recommendation 8* which offers a generic rather than personality disorder specific approach toward service provision. The goal remains that individuals are able to access an *enabling environment which is psychologically and trauma informed* and which is connected to other non-secure and community pathways.

Unfortunately there remains a lack of community options, including 'step-down' services for men with a diagnosis of personality disorder in secure services across the region. Tiers 1-3 community services are well placed to play a key role in reducing the likelihood of offending behaviour given the significant number of men in secure services that have had previous contact with mental health services prior to offending. Therefore a key priority may not be the need for Personality Disorder Tier 4 services as they are for women but the development of Tiers 1 -3.

The requirement for 'step-down' services is supported by the findings of the Swale ward service evaluation, a personality disorder specific medium secure service for men at the Humber Centre, as

part of the *Personality Disorder Pathway Strategy*. Only approximately half of men admitted over a 10 year period were able to succeed in discharge to less secure placements and the lack of such options was suggested as a key issue.

There remain a number of issues that need further discussion, clarification and agreement from local *Provider Collaboratives* within the existing personality disorder specific pathway for men and which form further sub recommendations.

Recommendation 9b: *Secure services and the CJS must develop arrangements that enable effective planning and delivery of pathways to ensure the most appropriate and timely service are identified for men with a diagnosis of personality disorder.*

The *Personality Disorder Pathway Strategy* has identified a need for closer working arrangements between personality disorder specific medium and low secure services and the CJS. This includes the Offender Personality Disorder (OPD) pathway and the Beacon service at HMP Garth to ensure a *'whole systems'* approach is in place. This stems from the significant number of men who enter secure services via the CJS as compared to women and the challenges of discharge for those men on restriction orders in particular and the lack of appropriate service provision available including high support 'step-down' services as described in *Recommendation 9a*.

A reiteration of the principles of the OPD programme as identified within *The Offender Personality Disorder Pathway Strategy* (2015) would be helpful:

- Male offenders with severe personality disorder who present a high risk of harm to others to be primarily managed through the CJS with the lead role held by Offender Managers.
- Responsibility for this population to be shared by NOMS and the NHS. Operations are jointly delivered demonstrating a collaborative culture in all aspects of service delivery.
- Planning and delivery to be based on a *'whole system'* and *'community to community'* approach across the CJS and the NHS, recognising the various stages of the individuals journey from sentence through prison and/or NHS detention to community based provision.

A number of key questions require discussion to enable a more informed understanding of the needs of men that enter the CJS before pathways can be better planned:

1. Have we an informed understanding of all key stakeholders and current pathways within the Yorkshire and Humber region?
2. Are we able to understand the key clinical, social and psychological factors (including experiences of trauma) that may be more likely to contribute to the need for transfer to secure services?
3. Are we able to identify the key factors and subsequent outcomes for men with a diagnosis of personality disorder who are prematurely returned to prison from secure services?
4. Are we able to identify the key factors and subsequent outcomes for men with a diagnosis of personality disorder who remain in secure services?
5. Do we have the forums and arrangements in place to develop closer working partnership arrangements between the OPD and secure services? If so are they currently fit for purpose?
6. Can we utilise the tiered pathway and clinical communities network approaches to better inform pathways and practice for this group of men?

Identifying answers to the above questions may provide service providers with a more informed and shared understanding of why such men are likely to be referred to secure services and lead to closer collaboration between the OPD pathway and secure services in developing appropriate pathways and services. It is recommended all relevant stakeholders from secure services and CJS engage in the appropriate NHS England commissioning forums to discuss the above questions in order to plan a more integrated pathway between offender and secure service pathways.

Recommendation 9c: *Further progression of a 'community to community' pathway by for men by developing high support 'step-down' services and supported residential living provision.*

A proposed model of residential provision available to men has been completed by Caroline Burnley, Community Links Personality Disorder and Offender Services Manager as part of the *Personality Disorder Pathway Strategy*. The options offer both a 'step down' service as well as supported residential living provision.

Firstly a lack of 'step-down' services for men with a diagnosis of personality disorder leaving secure services has been consistently identified as a key pathway requirement by all stakeholders. It is therefore recommended a high support 'step-down' service for men with a diagnosis of personality disorder and/or significant history of trauma is considered for each local *STP* area given the number of men requiring access to such a service.

Any high support 'step-down' service should be an *enabling environment which is psychologically and trauma informed* which helps develop the *creation of comprehensive, co-ordinated and*

connected spectrum of services within a 'community to community' pathway for men. The development of this service should consider closely the role, functions and experiences of Garrow House as it continues to provide a similar 'step-down' function for women. The proposed service would be a registered hospital providing a full range of multi-disciplinary interventions including 24 hour nursing care which would satisfy Ministry of Justice requirements for men with restriction orders.

The service would ideally be based within a community setting but realistically may be located within the grounds of an existing hospital given the significant offending histories of some men. However, it would seek to enable access to community facilities and services as much as possible. The high support 'step-down' service would seek extensive partnerships with Third sector organisations in the delivery of supported housing as well as employment and vocational opportunities. Entry in the service would have clear criteria; being a service for men leaving secure services or rehabilitation services and who have a history of offending or high risk behaviours.

A second proposal for future service provision includes access to supported residential living provision within the community. This would aim to provide an option for men at various stages of the pathway who require a safe therapeutic space with a focus on support and engagement within a residential community setting. Such community residential services are available within the region but are low in number and not always accessible in each *STP* area. Most are provided by the Third sector that has experience of delivering such services for male offenders and those under restriction orders. The development of partnerships between secure services and Third sector organisations will be crucial in the future commissioning of services that meet the needs of the male offender population.

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