Personality Disorder Pathway Strategy for the Yorkshire and Humber Region:

Making Connections and Delivering Community to Community Pathways.

Part 2: Underpinning Evidence Base

Contents

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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

Section 1: Development of Personality Disorder Services: Key Policies and Guidance

Managing Dangerous People with Severe Personality Disorder

The Managing Dangerous People with Severe Personality Disorder (Department of Health, 1999) initiative was collaboration between the Ministry of Justice and Department of Heath which aimed to assess, manage and treat individuals with a Dangerous Severe Personality Disorder (DSPD). It was acknowledged the term 'severe personality disorder' was not a single clinical diagnosis but a functional definition. DSPD services sought to remedy the lack of treatment available for such individuals presenting a danger to the public.

The first pilot site for the high-security DSPD service opened in 2001 and subsequent services were established in four sites; two in high secure prisons and two in high secure hospitals. Individuals were considered to meet the criteria for admission to DSPD high secure services if they were assessed as being more likely than not to re-offend, resulting in serious physical or psychological harm from which the victim would find it difficult or impossible to recover. The risk of re-offending had to be linked to the presence of a severe personality disorder. Those without a serious offending history were unlikely to meet such criteria, and the main client group were to be found in prisons, especially in the high secure estate. The DSPD initiative was introduced against overwhelming opposition from mental health professionals and others concerned with the implications of extending the public protection agenda through the use of a questionable medical 'diagnosis' (Duggan, 2011).

Ultimately, DSPD services found that demonstrating a functional (or evidential) link between severe personality disorder and dangerousness was a demanding criterion that proved elusive (Duggan and Howard, 2009). It was argued that the 'treatments' employed to reduce severe personality disorder and dangerousness were heterogeneous, often with little theoretical rationale for their application (Tyrer *et al*, 2009). Consequently, it was difficult to determine when an individual ought to move from a DSPD service to a lower level of security on the basis that their treatment needs had been met and risk reduced. On a more positive note, this new interest in personality disorder had effects beyond DSPD, highlighting the many individuals with a diagnosis of personality disorder in the community, whose needs had hitherto been largely ignored (Duggan, 2011).

Personality Disorder: No Longer Diagnosis of Exclusion

Publication of *Personality Disorder: No Longer Diagnosis of Exclusion* (Department of Health, 2003) guidance was a landmark document which revealed concerns regarding the quality and availability of services for individuals and challenged healthcare providers to address major shortcomings. It highlighted variability in practice as well as institutionalised stigmatisation. This stigmatisation explicitly excluded individuals with a diagnosis of personality disorder from accessing mainstream mental health service provision. It emphasised the need to place the individuals receiving services at the heart of involvement including co-production in the delivery of services at all stages.

Findings were based on a national survey issued to all Mental Health NHS Trusts in England in 2002. This identified that only 17% of NHS Trusts had a dedicated personality disorder service, 40% provided some level of service and 28% had no identified service and appeared to have little or no focus on such service provision. The findings indicated a significant disparity in the availability of services. Amongst those Trusts providing personality disorder specific services, there were inconsistencies in treatment approaches and delivery of service, likely to result in inappropriate care pathways and interventions. Further issues identified included mental health professionals lacking the knowledge, skills and training for effectively working with individuals with a diagnosis of personality disorder.

The publication set out broad principles for how personality disorder specific services should be developed:

- Multidisciplinary in focus.
- Follow a hub-and-spoke model.
- Assess and manage a range of risk factors.
- Provide care under the auspices of the Care Programme Approach (CPA).
- Provide specialist biological, psychological and social interventions
- Deliver training and consultation.
- Support the development of service user networks.

Personality Disorder: No Longer Diagnosis of Exclusion (2003) policy implementation guidance recommended development of specialist services for individuals with a diagnosis of personality disorder in all Mental Health NHS Trusts. It was anticipated the guidance would be supported by mental health and social care professionals and development of services would provide the help needed and lessen stigmatisation. This was the first Department of Health policy guidance which introduced the concept of dedicated and specialist personality disorder services.

As part of the national survey, a questionnaire was issued to all Trusts providing medium secure services and to independent sector providers of secure services. This provided evidence of the limited availability of services for individuals with a diagnosis of personality disorder. It identified several medium secure services actively excluded individuals with a primary diagnosis of personality disorder because they believed their service had neither the skills, training nor resources to provide an adequate provision.

This national survey identified almost all individuals in secure services were held under sections of the Mental Health Act (MHA). The MHA at the time was often interpreted as excluding those with a diagnosis of personality disorder from compulsory detention. This was because of the requirement that mental disorder be *"treatable"* (i.e. treatment is likely to alleviate or prevent deterioration in the patient's condition). Many clinicians did not view personality disorder as a mental disorder that was treatable. This significant issue changed with new mental health legislation contained in the revised *Mental Health Act* (Department of Health, 2007). This removed the treatability clause, and provided a reclassification and generic description of mental disorder (*"any disorder or disability of*

the mind") and that appropriate treatment should be available. This indicated a cultural shift in mental health services towards personality disorder as mainstream mental health business.

Personality Disorder: No Longer a Diagnosis of Exclusion introduced recommendations which included how best secure services deliver interventions. This was based on access to the same resources as those available within general mental health services where expertise and access to dedicated resources were required. The introduction and expansion of personality disorder specific secure services rapidly developed within the independent sector and was initially focused on male pathways.

Capability Frameworks

The *National Institute for Mental Health in England* (*NIMHE*) published a capabilities framework for the development of skills for all practitioners working with individuals with a diagnosis of personality disorder: *Breaking the Cycle: The Personality Disorder Capabilities Framework* (Department of Health, 2003). This guidance provided a starting point to consider the skill mix required within the workforce. It described new training initiatives to underpin the policy implementation process contained in the *Personality Disorder: No Longer Diagnosis of Exclusion* guidance. A framework approach was utilised which identified specific capabilities required of the workforce in a range of settings and across the whole system. Embedded within this framework approach were a number of clear principles aimed at breaking the cycle of rejection which had characterised debate about personality disorder and shaped service delivery.

In 2007, further to the development of workforce capabilities and competencies, Department of Health and Ministry of Justice commissioned *Personality Disorder Knowledge and Understanding Framework (KUF)* programme. The programme was delivered by a coalition of several academic organisations and service user groups and provided a new national education and training package for all practitioners across health, social care and CJS that had contact with individuals with a diagnosis of personality disorder. *KUF initially* offered a variety of training and education including awareness, graduate and post graduate levels.

NICE Guidance

Subsequently in 2009, the *National Institute for Health and Care Excellence (NICE) Guidelines on Borderline Personality Disorder: Treatment and Management* and *Antisocial Personality Disorder; Treatment, Management and Prevention* provided a number of recommendations for the NHS which aimed to address shortcomings in the recognition, management and treatment of personality disorder. NICE specified Mental Health NHS Trusts develop specialist multidisciplinary teams and/or services for individuals with a diagnosis of personality disorder and set out broad principles for developing services in line with the *Personality Disorder: No Longer Diagnosis of Exclusion* guidance. NICE supported training of all mental health staff members by personality disorder specific teams based in Trusts. It detailed a range of preventative interventions for children and young people at risk of developing Antisocial Personality Disorder (ASPD) and their families. This highlighted the importance of collaborative inter-agency networks in supporting and managing offenders with a diagnosis of personality disorder.

Recognising Complexity

Recognising Complexity: Commissioning Guidance for Personality Disorder (Department of Health, 2009) was based on learning from the *Department of Health National Personality Disorder Programme*. This included identification of best practice from pilot services and feedback from service users. The guidance aimed to support commissioners to work collaboratively in order to address need and improve outcomes for individuals. It recognised this group of individuals was diverse and formed part of a complex profile of need across many service users and age groups. It was proposed that effective commissioning must depend on recognising this complexity and should consider a wide range of vulnerable individuals with complex needs. The guidance provided clear direction to commissioners in order to address gaps in provision with a focus on integrated services and suggested commissioning for specialist groups of individuals and required outcomes.

Bradley Report

Also in 2009, the *Bradley Report* (Department of Health, 2009) described current availability of personality disorder appropriate services within mainstream or specialist mental health services as limited. The report was hopeful that changes to the revised *Mental Health Act* (2007) would be beneficial and inclusive. This included the principle that personality disorder was a mainstream condition requiring equal and appropriate consideration for assessment and treatment.

The report described 3 personality disorder related recommendations which attempted to build on learning over the previous six years from the DSPD programme:

1. An evaluation of treatment options for prisoners with a diagnosis of personality disorder should be conducted.
2. An evaluation of the DSPD programme should be conducted, to ensure that it is able to address the level of need.
3. In conjunction with Department of Health, National Offender Management Service (NOMS) and the NHS should develop an inter-departmental strategy for the management of all levels of personality disorder provision. This should include the management of individuals into and through custody, and also into the community.

Following on from the DSPD initiative, government sought to further reform services for high risk offenders with severe personality disorder. Reform included development of an offender pathway which would include timely access to personality disorder specific treatment and management services. The *Consultation on the Offender Personality Disorder Pathway Implementation Plan* (Department of Health, 2011) envisaged the phased reduction in size of the pilot DSPD units in high and medium secure NHS hospitals and phased withdrawal of central funding from other DSPD projects. This would allow reinvestment to increase the number of treatment places available in prison as well as improve case management services. It also proposed the development of robust

care pathways in partnership between the NHS and CJS. This commenced a phase out and demise of the DSPD Programme although many men admitted to DSPD high secure services remain in situ due to continued risk and safety factors and lack of 'step-down' options.

Offender Personality Disorder Pathway Programme

The Offender Personality Disorder (OPD) pathway programme was initiated in in 2011, in response to the *Bradley Report* and the *Consultation on the Offender Personality Disorder Pathway Implementation Plan*. Its key task was to meet the joint strategic aims of the Ministry of Justice and the Department of Health, and their respective agencies. The OPD pathway programme remains a jointly commissioned initiative that aims to provide a pathway of psychologically informed services for a highly complex and challenging offender group. Individuals are likely to have a severe personality disorder and pose a high risk of harm to others, or a high risk of reoffending in a harmful way.

The Offender Personality Disorder Pathway Strategy (Ministry of Justice, 2015) contained the desired outcomes of the OPD programme including improvement of public protection and the psychological health of offenders through developing comprehensive and effective pathway of services.

The main strategic aims included:

- The personality disordered offender population is accepted as a shared responsibility of the CJS and the NHS and are managed through joint operations.
- Services are primarily based in the CJS involving collaborative delivery with the NHS.
- Future planning and development is on a whole systems pathway basis involving the participation of Third sector agencies and Local Authorities.
- Staff members to receive appropriate support and training via development of KUF.

It ensured that offenders with the most complex psychological needs were identified early and public protection enhanced by addressing risk and psychological needs. This included psychologically informed lifelong case management where risk is associated with personality disorder.

The OPD provision continues to be evaluated and developed and offers valuable learning in the development and implementation of services for non-offenders with a diagnosis of personality disorder which is explored further in the *Personality Disorder Pathway Strategy.*

Specialist Personality Disorder Services

The cross-government mental health strategy *No Health without Mental Health* (Department of Health and Social Care, 2011) set out the government's strategy on mental health after the NICE clinical guidelines in 2009. This included a commitment to reduce inequality of access to services for those with a diagnosis of personality disorder. These commitments were further supported by the *Talking Therapies: a Four Year Plan of Action* (Centre for Mental Health, 2012), which aimed to expand and improve access to psychological therapies and *No Heath without Mental Health: Implementation Framework* (Centre for Mental Health *et al,* 2012).

It is interesting to note that access to personality disorder specific services within the East Midlands was also investigated during this time. Research indicated the capacity to meet the needs of individuals with a diagnosis of personality disorder, including both offenders and non-offenders, was inadequate (Tetley *et al*, 2011). Such a view supported the initial findings in *Personality Disorder: No Longer Diagnosis of Exclusion* in 2003 and suggested little progress in service development. The findings reported the disparity across various interventions within East Midlands. Although researchers proposed similar observations may apply throughout England, it noted no systematic attempts on a national scale had been completed to understand the availability and management of personality disorder specific services.

In 2014, the *National Personality Disorder Service Review Group* formed to evaluate the extent to which variable service availability affected individuals with a diagnosis of personality disorder. This professional group used *Personality Disorder: No Longer Diagnosis of Exclusion* guidance as a benchmark to review services within the context of a *National Survey* (Dale *et al*, 2017). This survey was a systematic attempt to map the personality disorder specific service provision across England. The findings revealed that 84% of organisations in England had at least one personality disorder specific service, and in organisations with no specialist services, all provisions for personality disorder were via a generic service. This represented a fivefold increase compared with the 2003 national survey described in the *Personality Disorder: No Longer Diagnosis of Exclusion* and therefore substantial progress at an organisational level. However, despite a substantial increase of personality disorder specific services, only 55% of organisations reported individuals with a diagnosis of personality disorder had equal access to their services.

Availability and nature of personality disorder specific services were compared to those received by individuals with a diagnosis of personality disorder found in generic mental health services. It identified personality disorder specific services were no more likely to provide personality disorder specific interventions when compared with generic services. The survey evaluated the provision of services compared to NICE quality indicators and explored differences between such specialist and generic services. The *National Survey* concluded that the 10 years since the *Personality Disorder: No Longer Diagnosis of Exclusion* publication had seen considerable progress in providing services for individuals with a diagnosis of personality disorder but there remained evidence of continued exclusion, variability of practice and inconsistencies in the availability of services. There remained a need for the establishment of authoritative commissioning guidance and development and implementation of service standards to ensure that service users and carers access the care needed. (Dale *et al,* 2017).

Finally, the concept of specialist personality disorder services was formally introduced in the *Personality Disorder: No Longer Diagnosis of Exclusion* publication, although little was known about how services should be configured at the time (Crawford *et al*, 2008). Added to this, there remains no existing guidelines or agreement to date in terms of what constitutes a personality disorder specific service and the notion has been used differently over the years without reasonable definitions (NICE, 2003; Price *et al,* 2009; Crawford *et al*, 2008; Dale *et al*, 2017).

Further Developments

Five-Year Forward View for Mental Health report (NHS England, 2016; Mental Health Taskforce, 2016) described key aims in supporting development of services for individuals with a diagnosis of personality disorder. This included expansion of proven and effective community based services, a focus on physical health care in primary care and further investment in improving access to psychological therapies. Care pathway development for both personality disorder and self-harm were also cited.

Despite the growth of personality disorder services within recent years, individuals with a diagnosis of personality disorder are still facing barriers when trying to access services. *The Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder (Mind et al 2018)* described the mental health system, including use of medication and standard psychological treatment, as not working effectively to meet the needs of individuals. Due to the complexity of difficulties and challenges, the statement suggests mental health services alone will not be able to meet the needs of individuals. A new way of thinking and the development of a *'whole systems'* approach is recommended which includes a multi-agency perspective which seeks to meet complex psychological needs.

Section 2: Strategic Context of Mental Health Service Provision

2.0 National Policy Context

In 2014, NHS England published the *NHS Five year Forward View* (*Forward View*), which described how health and care services would be required to change in order to meet the needs of the population (NHS England *et al,* 2014). The report emphasised the need for integration of services across organisational boundaries, greater emphasis on prevention, and for individuals and communities to be given more control of their health needs.

New Care Models aimed to create a new platform to support cross-organisational change across local health and care systems to contribute to the triple aim of improved care, reduced cost and better population health. *Forward View* described several *New Care Models*, and identified areas of the country which were selected as 'vanguards' to lead their development. *New Care Models* also introduced the aim of dissolving traditional boundaries in the NHS, by bringing together fragmented budgets and services into coherent local systems of care (NHS England *et al,* 2014). This created an opportunity to deliver whole-person care responsive to mental health, physical health and social needs.

Forward View identified NHS planning guidance including creation of *Sustainability and Transformation* Plans (*STPs*) as local vehicles and the main mechanism to implement changes. This included strategic planning and collaboration between partners with the aim to help meet a 'triple challenge' set out in *Forward View:* Better health, transformed quality of care delivery and sustainable finances.

STP's intended to bring together all partners to develop long-term plans for the future of health and care services in their area and was expected to outline how they would improve quality and efficiency of care (Alderwick *et al* 2016). The geographical 'footprints' for the *STP's* within the region included West Yorkshire and Harrogate, South Yorkshire and Bassetlaw and Humber Coast and Vale.

The emphasis of STP's gradually shifted towards a focus on developing and strengthening local place-based partnerships. In 2017, *Next Steps on the NHS Five year Forward View* (*Next Steps*) reframed STP's as *Sustainability and Transformation Partnerships* (NHS England 2017). The aim was for *STP's* to evolve into accountable care systems later renamed as *Integrated Care Systems (ICS's)*. *ICS's* were described as progressive versions of *STP's* in which NHS organisations (both commissioners and providers), and other partners, would choose to take on collective responsibility for resources and population health. *STP's* within the regional hub were thought to provide a collaborative system of leadership and governance which would allow *New Care Models* to evolve and spread. In April 2017, *STP's* became the single application and approval point for local organisations to access NHS transformation funding.

2.1 Mental Health Policy Context

The *Mental Health Taskforce*, set up by NHS England in March 2015, was tasked with developing a five-year, all age national strategy for mental health in England to 2020, aligned to the *Forward View*. Its final report, *Five Year Forward View for Mental Health* (*Mental Health Forward View*) published in February 2016 set out the overall aim to transform mental health care and improve mental health and wellbeing across the population. It described key recommendations relating to development of secure care pathways:

> *"NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery and 'step-down' for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and identify new co-commissioning, funding and service models. This work should also tackle inequalities for groups shown to be over-represented in detention and lengthy stays, and seek to ensure that out of area placements are substantially reduced".*

Mental Health Forward View proposed a mental health pathway and infrastructure development programme. This ensured individuals diagnosed with a mental health condition, including personality disorder, have timely access to the full range of interventions as recommended by NICE guidelines and quality standards and receive the 'right care, first time'. The proposed programme included work to ensure individuals who are already receiving support receive care that is fully NICE-concordant, including psychological therapy, as a core part of co-produced care plans that are recovery and outcome-focused.

In 2016, NHS England implemented a *Mental Health Service Review* which identified the need for regional planning and delivery of services including local decisions on how finances are allocated and spent. The review noted the importance of supporting mental health strategy and policy and aimed to ensure the right services were commissioned in the right place and could be accessed at the right time with equality of access to high quality services. The review has been co-ordinated nationally for local delivery and implementation by NHS England.

Subsequently, the *Adult Secure Mental Health Service Review* programme was initiated. It described how adult secure mental health services functioned and how individuals access secure services. This review led to changes in the specifications for low and medium secure services which had been individually developed in 2012/2013. The *NHS England Clinical Reference Group* detailed changes required and service specifications were updated and combined in March 2018.

Two new appendices were developed which described the requirements for Access Assessment and Forensic Outreach and Liaison Services (FOLS):

- Access Assessment Services enable appropriate access to all secure services including where an increase or decrease in the level of security is required or transfer from prison or Immigration Removal Centre for treatment in a secure service is requested.
- FOLS support and facilitate delivery of effective transitions of high risk individuals from secure services into the community. FOLS deliver interventions aimed at reducing risk of relapse, reoffending and readmissions.

The *Adult Secure Mental Health Service Review* programme continued to deliver the recommendations contained in the *Mental Health Forward View*. It aimed to substantially reduce the number of individuals sent 'out of area' to secure services, and reduce dependency on hospital beds through increased community provision including:

- Transformation of pathways in and out of secure services, in collaboration with those who use services, carers and stakeholders.
- Development of the secure care pathway that will be shaped by the results of a 12-month trial to test provider-led commissioning for medium and low secure services which incentivise the least restrictive care possible, closer to home.
- A workforce strategy to support the development of community service models and an analysis of demand and improved data collection.

NHS England emphasized the requirement to continue to work in partnership with its regulatory and NHS partners to put into place the cross-system support needed to deliver this programme and embed good quality community services within the secure services pathway.

Implementing the Mental Health Forward View (NHS England 2016) described the introduction of an implementation plan to 2020/21. The plan made clear successful implementation was dependent upon establishing services which are sustainable for the long-term. The plan contained objectives and commitments with the aim to deliver improved access to high-quality care, more integrated services and earlier interventions. A common theme across many of the objectives was of building capacity within community-based services to reduce demand and release capacity from the acute sector and in-patient beds. A further theme is moving the commissioning model for in-patient beds in mental health services towards a more 'place-based' commissioning approach so pathways are better aligned and efficiencies more readily realised *(Ham and Alderwick, 2015)*.

Kings Fund *Mental Health and New Models of Care (2017)* described lessons learnt from 50 national vanguard sites including how integration of mental health within *New Care Models* would look like. This followed a process of engagement with stakeholders aimed to identify key design principles to guide development of integrated approaches to mental health. The following 9 principles were identified:

1. Commissioning, design and implementation of consistent with requirement to deliver parity of esteem i.e. valuing mental health equally with physical health.
2. Mental health considered from the initial design stages.
3. Address and measure outcomes that are important to service users via a process of co-design.
4. A whole-person approach spanning an individual's physical, mental and social needs.
5. Extend beyond NHS services to include organisations that may impact on individual's health and wellbeing.
6. Invest in building relationships and networks between mental and physical health care professionals.
7. Enhance provision of upstream, preventative interventions to improve mental health and wellbeing.
8. Every clinical interaction seen as an opportunity to promote mental and physical wellbeing.
9. All frontline staff members receive appropriate training in mental health, regardless of the setting in which they work.

During January 2019, the *NHS long-term plan* (formerly known as the 10-year plan) was published setting out key ambitions over the next 10 years and built on the policy platform laid out in the *Forward View.*

2.2 Yorkshire and Humber Regional Developments

The *Forward View* and *Adult Secure Mental Health Service Review* provide the strategic context and framework for greater collaboration and partnership working in the planning and delivery of secure services. The principles embodied by these initiatives stress the importance of greater integration and collaboration across the health and social care system, to achieve improved quality outcomes for individuals, and greater efficiency across the healthcare system.

The *Adult Secure Mental Health Service Review* is currently delivered nationally for local delivery and implementation. It identified the need for all NHS England specialist commissioning regional hubs to develop a three to five year capacity plan for their population. Such plans outline how the current range of specialist secure provision will be developed to meet a number of national objectives:

- Ensure when secure mental health beds are accessed that the 'least restrictive' option is available at all times in all locations.
- Ensure bed availability is aligned with appropriate non-secure in-patient and community provision and with prison mental health services.
- Eliminate inappropriate out of area placements.
- Encourage integration and collaboration between commissioners and providers to create local pathways.
- Commission high quality and clinically effective services through outcome focussed service specifications.

Locally, 3 adult secure *STP* based *Partnership Forums* (now named *Provider Collaboratives*) are to be developed to deliver improved outcomes, connected pathways and greater partnership and integration across services. Each *STP* is intended to have a lead provider within the *Provider Collaboratives*.

A number of key principles were identified from a Yorkshire and Humber perspective within the *Adult Medium and Low Secure Mental Health Service Review – Yorkshire and Humber Hub: STP Partnership Forums - Statement of Purpose* (2017):

- Care provided as close to home and family and friends as possible, and reflect individual choice
- Care provided in the least restrictive environment.
- Needs of the *STP* population met within the *STP* boundary unless the partnership agrees that some specialist needs of the population are best met through multi *STP* services.
- Some medium secure and highly specialised services **may** need to be provided at a Yorkshire and Humber or even at a national level.
- For women – needs and victim related issues 'trumps' diagnosis in terms of service planning and delivery.

Adult Secure Mental Health Service Review has triggered a number of underpinning work streams. This ensures decisions affecting current capacity and existing pathways are informed by best practice and evidence base, and risk to the secure services, including its work force are kept to a minimum. Therefore work is currently being taken forward nationally to identify best practice regarding the needs of women, prison in-reach, community mental health provision and how best to commission across whole pathways

The *Yorkshire and Humber Capacity Plan* was submitted as part of the national *Adult Secure Mental Health Service Review* process of ratification and coordination and was informed by a series of provider consultation events held in 2017 as part of the engagement process for the *Adult Secure Mental Health Service Review.* During this review, stakeholders had the opportunity to identify and discuss key priorities.

Also completed was the *Adult Secure Capacity and Population Review* of the current Yorkshire and the Humber population residing within medium and low secure services and outside of the area. This identified the need for the following:

- Devolved commissioning arrangements including *New Care Models* with an emphasis on pathway development.
- Reduced length of stay.
- Better integration across a range of agencies and providers along the pathway.

A key strategic goal is less reliance on secure service beds which enables resources to be released to reinvest elsewhere in the pathway including development of community provision within a framework of effective integrated pathways.

In March 2018, NHS England informed all NHS and Independent Sector providers that the *New Care Model* programme would be extended beyond the initial two years. Regionally this means that the three adult secure *STP* based *Provider Collaboratives* would continue with delegated commissioning arrangements. Subsequently, NHS England is seeking to achieve an integrated care pathway for community and secure services across the region. This will deliver on new specifications for low and medium secure services, Access Assessment Services and FOLS as well as helping to achieve the service reduction ambition. All of the above will be supported by devolved commissioning arrangements within the three *STP* areas via *New Care Models*.

Introduction to Sections 3 to 7

It is not the intention to comprehensively 'map out' the various available pathways and services available for individuals with a diagnosis of personality disorder. This would be protracted and not of significant value and therefore the following sections provide a generalised description of services and availability of pathways including best practice:

- **Section 3 Mental Health pathways**
- **Section 4 Personality Disorder pathways**
- **Section 5 Secure pathways**
- **Section 6 Criminal Justice pathways**

Section 3: Mental Health Pathways

3.0 Acute Mental Health Pathways

Acute Mental Health Services

Acute mental health services work with people who are either (a) experiencing, (b) at risk of, or (c) recovering from a mental health crisis and should include individuals with a diagnosis of personality disorder. These services should:

- Meet the mental health needs of those individuals who cannot be managed by primary care and specialist community-based services.
- Include crisis resolution and home treatment services and inpatient services.
- Include a range of community-based supports that may be commissioned to complement treatment at home or in hospital.

The Joint Commissioning Panel for Mental Health, 2013 describes the aim of an acute mental health service pathway is to support individuals and their families by undertaking a thorough assessment, ensuring the individual's safety, identifying recovery goals and implementing a care plan. This starts the individual on a trajectory of recovery that enables them to move forward with less intensive services.

Community based mental health service provision may include the following:

Crisis Resolution and Home Treatment Team (CRHT): A multidisciplinary team that operates on a mobile basis 24 hours a day, 7 days a week providing treatment at home for those acutely unwell who would otherwise require hospital admission. Such teams generally 'gate-keep' (assesses the appropriateness) of inpatient admissions, and facilitates early supported discharges. Some Trusts have reorganised their structures and provide this function as part of a wider Community Mental Health Team (CMHT) approach.

Crisis House and Recovery House Provision: Community-based crisis services which provide support in a residential setting to individuals in crisis who cannot be treated at home but who may not need to be admitted to hospital. This provision is often made by, or in partnership with, local Third sector or social care organisations and CRHTs may provide a gate-keeping function. Such services are not consistently available within the local region.

Inpatient services: Provide a high standard of care and treatment in a safe and therapeutic setting for individuals in their most acute and vulnerable stage.

There are at least 3 types of inpatient service:

1. **General acute inpatient wards** usually provide inpatient facilities for a broad range of psychiatric diagnoses within a local area including those with a diagnosis of personality disorder. In some areas they are separated into acute assessment/triage wards and longer

stay/recovery wards. The length of stay is expected to be relatively short given the limited role of such services but may extend by such an extent for the admission to be termed a 'delayed discharge' especially when housing options are limited on discharge.

2. **Psychiatric intensive care units (PICU's)** are for individuals who are in an acutely disturbed phase which means they cannot be safely managed on acute wards. Length of stay is appropriate to clinical need and assessment of risk, but would aim not exceed eight weeks in duration. PICUs usually serve a wider catchment area population than a CRHT or admission ward.

3. **Specialist inpatient services** may include mother and baby units and eating disorder services, and are the subject of separate commissioning guidance by NHS England.

'Place of safety' provision: A small suite of rooms for the emergency psychiatric assessment of those detained by the police under S136 of the MHA. Police custody is sometimes used as a 'place of safety' but guidance makes it clear that this should be on an exceptional basis only and that it is preferable for the individual to be detained in a hospital or other healthcare setting.

Step-down and supported housing: Housing support may help reduce hospital admissions by signposting to other services and providing support for individuals leaving hospital. This may include managing a tenancy, living independently and connecting with services. Integrating housing support into discharge planning helps ensure discharge from acute services is not delayed. Services are almost always delivered by Third sector providers, and at times, in formal partnerships with local mental health providers.

Depending on the local context, other services within the region may link (directly or indirectly) to the acute mental health pathway. This includes Accident and Emergency/liaison services; acute medical wards; primary care services; community mental health services; early intervention services; drug and alcohol services; and assertive outreach services.

Analysis

Access to a range of services is available within the region for individuals with a diagnosis of personality disorder as part of a standard acute mental health pathway which may be found in most local areas. Services are usually planned and delivered under the auspices of local Mental Health NHS Trusts and generally commissioned by local Clinical Commissioning Groups (CCG'S). Services should not exclude those individuals with a diagnosis of personality disorder and therefore, be able to have their needs met by the pathway. Unfortunately, it is sometimes the case services and pathways are not able to meet the complex needs of such individuals, especially at times of crisis. This may lead to potential longer term hospital admissions and subsequent escalation into more restrictive services. This seems particularly pertinent for women with a diagnosis of personality disorder.

The Thematic Analysis and the Pathway Development Service and the *Personality Disorder Strategy Report: Staff and Service User Focus Groups* identified specific challenges found within the acute mental health pathway which are identified and discussed in more detail below.

- *Lack of available and integrated service provision*

A lack of integrated service provision was described including lack of community services for individuals with a diagnosis of personality disorder. This encompassed access to services within the acute mental health pathway including crisis resolution and home treatment. The *Thematic analysis* identified that individuals have limited choices in accessing services that are more likely to meet their needs: "*limited alternatives mean that they may end up with less support or somewhere where it's less suitable to them".* As a result, a significant number of individuals may enter acute hospital services in particular, and such services may struggle to meet their needs, as: *''there is a very large number of people who, probably, if they've had a good quality specialist community input, they wouldn't need to be in hospital''.* The *Thematic analysis* described admission to acute hospital services as likely to be iatrogenic and individuals could become more distressed leading to deterioration of mental health.

The findings from the *Staff and service user focus groups* identified that staff members thought there should be enhanced support available in the community when individuals are struggling or in crisis to prevent unnecessary hospital admissions. Any admission to hospital should be as a last resort and in the least restrictive environment. It should include support throughout the admission to ensure it is as short as possible with continuity of staffing offering consistent approach. Treatment should be offered in one hospital with no individual forced to transfer unnecessarily as this created emotional distress including difficulties in building relationships with new staff members and peers. Treatment should be as close to home as possible unless this is not wanted by the individual for specific reasons and therefore such decisions should be respected. Several service users described admission to hospital as inevitable even with community support.

Unfortunately pathways occur between acute wards to PICU's which may be out of area and provided by the independent sector. This triggers challenges both for individuals and services regarding isolation from, and connectivity to, local services and feelings of abandonment and rejection. In such situations, it was described as difficult for such local and out of area services to work closely together to meet the needs of the individual and to plan a pathway to the least restrictive environment. In such situations collaborative work with the individual to safely expedite transition and discharge to the individual's local area was also challenging especially if lack of service availability continued to be the case in the local area.

The *Thematic analysis* identified local services within the same acute mental health pathway often have difficulties in forming cohesive and connected pathways. Admissions to acute inpatient services may be extended, leading to increasing episodes of crisis likely to lead to an even lengthier hospital admission and increased risk. Experience suggests this is likely to include transfer to personality disorder specific out of area locked rehabilitation and secure services when alternative community options have not been previously available. This pathway seems particularly likely for women with a diagnosis of personality disorder.

- *Availability of psychologically informed services*

The availability of psychologically informed services within the acute mental health pathway was described as variable within local areas. The *Thematic analysis* described services within pathways often fail to recognise the importance of developing a shared understanding of the individual to inform safe and effective risk management, especially at times of crisis *''it is difficult to anticipate and plan for risk if you haven't got a formulation''.* Subsequently acute mental health pathway services struggle to safely manage risk behaviours such as self-harm, without a psychological understanding of the function of behaviours being available. Individual needs remain poorly understood and it is unclear how meaningful decisions can be made without a formulation which informs and directs key aspects of the individuals care.

From the *Staff and service user focus groups* experience, staff members described the positives of an available clinical model including an approach to care and treatment that is based on formulation and ensures consistency of approach from the workforce. Such an approach needs to be well-led and supportive for all involved.

- *Crisis Planning*

The *Thematic analysis* and *Staff focus groups* identified effective planning and management of crisis to be important including positive risk management. Better understanding and managing periods of crisis were suggested as key interventions and principles when working with individuals who present in ways which are harmful to self and others. Therefore inability to tolerate and accept understandable risks, may lead to increased levels of frustration from the individual and staff members. Episodes of crisis, especially within the community, may trigger decisions regarding the individual's pathway which may lead to an escalation into hospital based services rather than remaining in the community.

It was highlighted risk and safety decisions should be informed and driven by effective assessment and formulation, which helps to understand the function of crisis for the individual; that they are not *''reaction skewed''* decisions responding to apparent and immediate needs of the individual. *Staff focus groups* described the need for community based staff members to be better equipped in working with individuals with a personality disorder, especially at times of crisis, including access to the appropriate training and education. *Service use focus groups* described how involvement in their own crisis planning was important.

- *Access to services*

The *Thematic analysis* and *Service user focus groups* suggested whilst crisis home treatment services are intended to provide the community-based treatment for individuals to reduce hospital admissions, access appears to be problematic for individuals with a diagnosis of personality disorder. Services intended to manage episodes of crisis often struggle to understand the needs of individuals as well as to determine the severity and likelihood of their risk especially when self-harm is present. Individuals may feel '*pushed away*' and the message they might receive is *''you're not risky enough, or you're not suicidal, or you're saying you are but I don't believe that you are so therefore there is a closed door here''.* Failure to effectively respond to the needs of individuals in crisis leads to increased risks as well as lengthy hospital admissions which may be unsuitable and have adverse effects.

Service user focus groups described consistent and long term access to a community based care co-ordinator whilst residing in secure services could be problematic. The need for improved and consistent input from care coordinators where a therapeutic relationship could be better developed was highlighted. This would consist of more frequent and regular visits to both the individual and attendance at CPA and clinical team meeting. This would lessen feelings that the individual had been forgotten and improve the planning of transition including discharge from secure services.

Access to appropriate services after discharge was also raised within both staff and service user focus groups. *Service user focus groups* described the making of a thorough discharge plan highlighting available community provision was critical. This process should include services working with the individual prior to discharge. This would create certainty for the individual and lessen anxiety. It was thought important that ongoing contact with the Recovery College should also be agreed prior to discharge.

Staff focus groups also highlighted the importance of accessing Recovery College after discharge and the need for 'step-down' residential services to be available, especially for men. Services should be involved in planning for transition and discharge at an early stage in the individuals admission. Appropriate housing was described as difficult to access and therefore housing and resettlement support services have an important role to play in the identification of suitable housing and discharge process but such services were often thought to be unavailable.

- Developing a capable and competent workforce

A further theme highlighted in the *Thematic analysis* was associated with staff members working within the acute mental health pathway who at times appear to lack the required knowledge, skills and support to work effectively with individuals with a diagnosis of personality disorder. Whilst KUF has been an invaluable source of support it has been mainly targeted within the CJS in the last several years and is therefore a limited resource. Therefore the capabilities and competencies of staff may not be fully developed and integrated with the needs of individuals and service requirements. It was suggested that services within the pathway tend not to operate closely regarding sharing and developing practice from working with individuals with a diagnosis of personality disorder.

Staff focus groups were clear that recruitment of the right staff members, productive induction, appropriate training, education opportunities, and a positive culture were all required. Recruitment should focus on finding motivated and passionate individuals; induction should better prepare staff members for the challenges of working in services; training and education should meet the needs of the workforce and be accessible whilst a positive culture should include robust support in the form of regular supervision and reflection opportunities.

- *Personality disorder specific services*

The *Thematic analysis* identified the apparent lack of available personality disorder specific provision throughout the acute mental health pathway. Services were thought to better meet the needs of such complex individuals at particular points within the pathway. Especially at times when crisis occurs or to coordinate the transition and discharge process from hospital. It was acknowledged that community based services able to meet the psychological needs of individuals with a diagnosis of personality disorder have become more apparent over the last few years, but personality disorder specific services remain under developed. *Service user focus groups* described community teams

who have the required psychological training and education, including being trauma informed, as the best equipped to understand individual needs, build relationships and plan and implement interventions.

Regarding personality disorder specific secure services, *Staff and service user focus groups* described a preference for working and living within such wards rather than mental illness services. Staff members described working in personality disorder specific wards that had access to a range of opportunities including psychologically informed training and education not apparent in non-personality disorder specific wards. They also found supervision, reflective practice and involvement in the formulation process as being helpful to their role.

Staff and service user focus groups acknowledged placing relatively large numbers of individuals with a diagnosis of personality disorder together in a closed environment could lead to interpersonal conflict. These included difficulties imposing boundaries and exposure to behaviours which are likely to learnt and copied, such as self-harm. *Service user focus groups* generally appeared to prefer their care and treatment to be based within personality disorder specific wards as this appeared to increase their access to a greater number of, and a more psychologically informed workforce, who were more able to better understand their needs. It was noted that such environments were often more relaxed and less intrusive from a service user perspective as they often contained fewer individuals with a diagnosis of psychosis.

Staff and service user focus groups, whilst describing a preference for working and living in personality disorder specific services, acknowledged that the key attributes of such services should be shared and provided within all ward areas in secure services. The acknowledgment and development of trauma informed care was specifically highlighted during such discussions.

Section 4: Personality Disorder Pathways

4.0 Community Services

The development of Personality Disorder Tiers 1-3 community services has been slow and piecemeal within the Yorkshire and Humber region even though NICE Guidance stipulates specialist interventions are best delivered by personality disorder specific services. The last 10 years or so has seen the development of some aspects of such tiered provision within local areas but often have significant differences in their function, application and resources.

Several community based services working with individuals with a diagnosis of personality disorder have effectively contributed to acute mental health pathways although integration with existing acute inpatient services remains challenging. More generic services are available across the locality with community mental health teams and assertive outreach teams often working with individuals with a diagnosis of personality disorder but struggle to make a positive impact.

Significant concerns expressed about the quality and accessibility of services for individuals with a diagnosis of personality disorder has been apparent for many years. Such concerns contributed to the Department of Health funding 11 dedicated personality disorder specific community-based pilot services in England in 2004. This was within the context of individuals being dissatisfied with existing services whilst many believed that the treatment they received declined as a result of being given the diagnosis. Subsequently the Leeds Personality Disorder Managed Clinical Network (PDMCN) was established in 2004 as one of the community pilot projects working with individuals with a diagnosis of personality disorder.

The PDMCN is a city wide multi-agency and multi-disciplinary service, provided by a range of partnership organisations including Leeds Partnerships NHS Foundation Trust; Community Links (Third sector provider); Leeds Survivor Led Crisis Service. Managed Clinical Networks (MCN's) have been described as linked groups of health professionals and organisations, working together in a co-ordinated manner, unconstrained by existing professional and organisational boundaries, to ensure equitable provision of high quality effective services. They are noted to be particularly effective when individuals present with a range of complex needs and where a set of autonomous organisations come together to reach goals that no one organisation can reach separately.

The PDMCN is described in more detail as the service offers a best practice example of an established community based Tier 3 personality disorder specific service that works effectively with individuals and services:

- *Care co-ordination*

Care co-ordination comprises of individual clinical case management for up to 100 weeks under the framework of Care Programme Approach (CPA)

- *Community Links Accommodation Services*

The Community Links personality disorder accommodation support aims to prevent homelessness by early intervention; to work closely on trigger issues and with agencies that identify them; and to offer short-term interventions or help the individual to move or to sustain existing tenancies longer term.

- *Psychological therapies*

A number of therapeutic approaches are offered, including Cognitive Behavioural Therapy (CBT); Schema-focused Therapy; DBT-Informed Therapy and Psychodynamic Psychotherapy. The team plays a significant role in supporting psychological thinking across the PDMCN through consultation and supervision.

- *Occupational therapy*

Occupational therapy offers assessment and intervention and also facilitates Journey day service.

- *City wide Dialectical Behaviour Therapy*

City Wide DDBT programme a "hub and spoke" model with DBT skills training group located in 3 local geographical areas all supported by the DBT consultation meeting.

- *Journey day programme*

Journey is a 16 week occupational therapy group work programme providing group members with the skills and knowledge to actively engage in creating an individual balance of occupations, which promote health and wellbeing.

- *Care pathway management*

A number of referrals to the PDMCN do not meet the service criteria. All referrers are provided with Care Pathway Management via advice, support and signposting.

- *Working with carers*

A 6 week educational course for carers which aims to provide education and support including self-care for the carer.

The PDMCN delivers the accredited KUF Awareness Level training. The PDMCN also provide clinical input to local acute mental health inpatient services for women which has enabled a personality disorder specific pathway to be created. The PDMCN continues to provide care coordination for individuals admitted to hospital including those placed within locked rehabilitation and secure services both within and out of area.

Analysis

The initial 11 pilot services provided alongside the PDMCN offered a diverse range of innovative approaches to helping individuals with a diagnosis of personality disorder which have helped inform the development of personality disorder specific community services. A report titled *Learning the Lessons: A Multi-method Evaluation of Dedicated Community-based Services for People with Personality Disorder (2007)* was published by the *National Co-ordinating Centre for NHS Service Delivery and Organisation.* There was broad agreement contained regarding the basic parameters for providing services:

- Be delivered over a relatively long period of time.
- Validate rather than dismiss individual experiences.
- Work flexibly with individuals while ensuring the service they provide is consistent and reliable
- Promote autonomy and choice.
- Deliver interventions of varying intensity to meet different levels of motivation.
- Facilitate access to peer support and group work.
- Help service users generate short and long-term goals.
- Help service users plan how they will deal with crisis.
- Ensure that individuals are given time to prepare for leaving the service.
- Deliver social as well as psychological interventions.
- Combine direct service provision with support for colleagues in other settings to increase capacity and decrease social exclusion.
- Ensure staff members work closely together and receive regular supervision.

Both the parameters of providing services for individuals with a diagnosis of personality disorder and desirable characteristics of staff members are crucial in thinking about planning and developing community services from a Tier 1-3 perspective including workforce needs. The desirable characteristics of staff members were identified within the evaluation report:

- Responsive, flexible, and boundaried.
- Ability to empower and not control individuals.
- Emotionally mature and have a high degree of personal resilience.
- Retain a positive attitude and able to accept the limitations of what can be done.
- Capacity and a willingness to reflect on themselves and their work.
- Discuss mistakes or uncertainty.
- Balance their work life with other aspects of their life.
- Work as team members, reach compromises and accept shared decision making.
- Staff members informed and knowledgeable about personality disorder.
- Staff members empathic, non-judgemental, open, genuine, 'real', and accessible.

The effectiveness of the PDMCN can be evidenced from the *Service and Commissioning Development Initiative* (Kane *et al*, 2016) which evaluated the cost and economic evaluation of the PDMCN. The final analysis identified the PDMCN achieved substantial reductions in health care usage (e.g. Accident and Emergency departments and GP's) in at least the short to medium term. An assessment supported indications from local commissioners that a relatively low number of out-of-area placements occurred in Leeds. There were further long-term beneficial effects to children growing up in more stable family environments. Through PDMCN support, individuals were better able to effectively engage with health services, reducing risks toward self and others and relapse. Findings support the notion that individuals with a diagnosis of personality disorder living in the community should not be confined to the margins of health care systems. Therefore the PDMCN must remain a service of interest for local areas hoping to develop personality disorder specific services.

4.1 Locked Rehabilitation

Recently, the term *'locked rehabilitation'* has become clinical parlance within mental health pathways given the growth of such provision. A significant number of locked rehabilitation services work with men and women with complex mental health difficulties that may have a diagnosis of personality disorder. Therefore they may describe themselves as personality disorder specific services. Such services may have higher levels of workforce resources and greater physical and environmental security than traditional rehabilitation services provided by local Mental Health NHS Trusts. Services may focus on individuals who are challenging to safely treat and manage and who lack engagement and motivation with the therapeutic process. Women are often admitted to services due to a lack of developed Personality Disorder Tier 1 to 4 Services whilst offering men a 'step-down' from secure services due to a lack of other options.

Individuals with a diagnosis of personality disorder admitted to locked rehabilitation services are often located out of area and within the independent sector due to the unavailability and inability of local inpatient and community based services to meet their complex needs in effective ways. Locked rehabilitation services generally have longer-term lengths of stay due to difficulties often assessing individual need and providing the required effective interventions within a collaborative relationship with individuals and local area services. A key difference between locked rehabilitation and low secure services relates to how services are commissioned. Whereas low secure services are currently commissioned by NHS England as part of the secure services pathway, locked rehabilitation units are generally funded on an individual or 'block' bed basis by CCG's.

Analysis

A recent Care Quality Commission (CQC) report *Mental Health Rehabilitation in Inpatient* services (2018) highlighted concern regarding the high number of beds in mental health rehabilitation inpatient services. Provision undoubtedly encompasses personality disorder specific services within a locked rehabilitation context within the independent sector. This was not analysed specifically within the CQC report. The main conclusions identified included:

- Individuals often receive care a long way from where they live and from support networks, which in turn affects their onward recovery and wellbeing.
- Individuals often accommodated in services 'dislocated' from their home areas. This is more prevalent in the independent sector than in NHS services.
- Independent sector provided more wards categorised as locked rehabilitation or complex care than NHS providers. Length of stay was longer in the independent sector when compared to NHS.
- Wide variation between CCG areas in use of rehabilitation and out of area beds.
- Services are a costly element of provision with out of area placements accounting for about two-thirds of this expenditure.

In response to the above findings, CQC recommended the Department of Health and Social Care, NHS England and NHS Improvement agree a plan to engage local health and care systems in a programme of work to reduce the number of individuals placed in mental health rehabilitation wards that are out of area. This may lead to the development of alternative local provision, including for those individuals with a diagnosis of personality disorder, especially within the context of locked rehabilitation services.

The above findings are fully supported by the PDS experience of completing a significant number of reviews and re-reviews of individuals with a diagnosis of personality disorder, especially for women, within personality disorder specific locked rehabilitation services. A number of key individual experiences and service characteristics have been identified which need to be recognised when planning potential alternative services. This includes that individuals have difficulties in trusting and engaging with services given their previous traumatic experiences and prior involvement with services where re-traumatisation has occurred. They are likely to have high levels of co-morbidity including substance misuse, significant mental illness and high impact risk and safety issues. Their level of personal autonomy and motivation may be severely compromised due to previous experiences and may lack of optimism and hope about the future.

Personality disorder specific locked rehabilitation services often appear unclear about specific rehabilitation and other key service tasks and subsequently lack a clinical model. They are likely to struggle to evidence a personality disorder 'specialism', and generally lack workforce resources and a robust support structure. For individuals within an out of area or regional placement, the effect of isolation and disconnection cannot be underestimated. It is the PDS understanding individuals generally lack regular and consistent interaction with their care co-ordinator which makes the monitoring and planning of care, including transition and discharge planning, extremely challenging. It is apparent, given the geographical distance of such placements, there is likely to be a lack of contact with family (including children) and friends leading to feelings of abandonment and separation.

Development of services and interventions to provide an alternative to personality disorder specific locked rehabilitation services requires a co-ordinated local pathways approach. From a PDS perspective, the admission of women into such services is often triggered by a lack of community resources. This includes access to services with specific knowledge and skills of working with individuals with a diagnosis of personality disorder. If needs are not met in the community, then a hospital admission into the acute mental health pathway is more likely. Due to a variety of factors, admissions have the potential to be prolonged and ultimately escalate into more restrictive services, including locked rehabilitation, due to an increase in risk to self and others.

Any strategic thinking about development of services that make admission into locked rehabilitation services less likely, needs to take into account availability of community resources and acute inpatient services. In the case of men, lack of options for 'step-down' from secure services leads to admission to locked rehabilitation services, often a significant distance away from their home area. Services need work in partnership, and be equipped to work with this population and to form connected pathways.

4.2 Personality Disorder Tier 4 Services

The Tier 4 Personality Disorder national service specification was completed in draft form in March 2014 by the *Personality Disorder Clinical Reference Group* on behalf of NHS England. Service specifications clearly define the standards of care and treatment expected from organisations funded by NHS England to provide specialised care.There followed a period of consultation but the specification was not ratified after the consultation ended in January 2015. There has been a subsequent restructuring to the Clinical Reference Groups within NHS England with the *Personality Disorder Clinical Reference Group* being integrated into a larger Specialised Mental Health Clinical Reference Group. A *Personality Disorder Advisory Group* was convened in 2017 to provide specialist advice and undertake key pieces of work. This included a revision of the original Tier 4 Personality Disorder service specification completed in 2018 which remains in draft version.

Tier 4 Personality Disorder services may provide specialist and intensive provision beyond that which can be provided within either local specialist (Personality Disorder Tier 1-3 Services) or other local mental health services. Whilst individuals admitted to Tier 4 services would not meet requirements for secure services (i.e. present a significant risk of harm to others) they will present with complexity and significant risk and safety issues which prevent effective engagement with local services. Such complexity may match women currently residing in personality disorder specific locked rehabilitation services in particular.

The defining characteristic of individuals referred to Tier 4 services is likely to be the incapacity of mainstream services to safely manage care and effect positive change. The predominant group of individuals appears to be mainly women with a diagnosis of BPD. Many have significant comorbid conditions such as substance misuse, complex post-traumatic stress disorder, transient psychosis and other mental disorders. At any one time, such individuals may display a range of 'high impact, high harm, high risk' behaviours toward self and /or others.

Tier 4 Personality Disorder Services are intended to enhance local and regional pathways for individuals with a diagnosis of severe and/or complex personality disorder and in a small number of cases will provide expert time limited interventions on an in-patient basis. This is intended to result in improved outcomes for individuals, progress care pathways and reduce inappropriate use of generic mental health, medical and surgical services.

It is intended that services will operate in a way that:

- Promotes psychological wellbeing, functional recovery and independence.
- Supports timely delivery of treatment interventions and provision of effective 'step-up' and 'step-down' pathways.
- Supports individuals to be actively involved in the planning and development of their care.
- Takes account of pathways into, and out of Tier 4 services, and actively helps to promote and reinforce pathways.
- Discharge individuals to local services which following a period of managed transition.

The function of Tier 4 Personality Disorder services should be to:

- Undertake structured assessment to determine service access.
- Provide clinical care in a structured environment and within a clinically coherent and personality disorder specific framework.
- Provide expert advice and liaison to Tiers 1-3 personality disorder services to help avoid admission at the higher tiers and support effective referral and discharge pathways.
- Operate to an evidence based clinical model, which explicitly states the parameters of the service, and to provide care in the least restrictive environment as possible.
- Collaborate with secure services as part of the overall pathway to ensure individuals leaving services are prepared for and supported to successfully reintegrate into the community.

The only current Tier 4 Personality Disorder Service within the Yorkshire and Humber region is the partnership of Garrow House and PDSS which is commissioned by NHS England.

Analysis

There remains uncertainty about the development of Tier 4 Personality Disorder Services given the process of developing an NHS England specification has been ongoing since 2014 and is yet to be fully completed. There are approximately five Tier 4 services nationally, with the majority working within their own service specification that pre-dates national Tier 4 developments and which do not appear to readily fit with the 2014 or the newly revised 2018 draft specifications. Existing Tier 4 services are a mixture of independent and NHS provision with all but one service being provided in the south of England. The service most meeting the current draft specification is the partnership between PDS and Garrow House which developed in 2014 as a response to the Personality Disorder Tier 4 NHS England specification.

It is difficult to examine Tier 4 provision from a national perspective as it remains relatively sparse, lacks clarity about the individuals such provision should aim to work with and therefore the type of services required. There remains a lack of understanding about gender specific needs, population size, clinical need and required service and clinical interventions. There remains a lack of clarity about future provision including commissioning arrangements from a national perspective and an understandable lack of awareness about such provision within regional and local areas.

The context of Tier 4 provision is further complicated by lack of Tiers 1-3 Personality Disorder services at both a national, regional and local area particularly for women. It has been suggested that most individuals with a diagnosis of personality disorder should be provided with services from Tiers 1-3 and those with the most severe and complex needs will require highly specialised Tier 4 services. Therefore it remains clear that the development of effective Tier 4 services relies on the development of Tier 1-3 and vice versa.

It is unclear whether future Personality Disorder Tier 4 capacity planning should include individuals, mainly women, currently placed within personality disorder specific locked rehabilitation services. This would seem a sensible approach given the high levels of complexity found although would

increase the number of women particularly requiring Tier 4 services. There appears to have been limited national discussion regarding the need for male Tier 4 provision given no such services currently exists. Therefore further consideration of current pathways for men may suggest only a limited Tier 4 provision may be required, if at all, within the region.

There remains a distinct commissioning arrangement to resolve for Personality Disorder Tier 4 Services. This includes the request by the Specialised Mental Health Clinical Reference Group in September 2018 to consider whether such Tier 4 services should form part of the devolved service portfolio as described by *New Care Models*. This is in the context of NHS England intending to expand the range of services covered by devolved commissioning arrangements and therefore establish a planned approach for all specialised mental health services including personality disorder. This work will identify services that should be commissioned /co-ordinated on a regional and/or national basis.

From a regional perspective there appears to be significant risks attached to a full alignment of Tier 4 Personality Disorder Services and *New Care Models*, not least of which would be establishing a personality disorder foothold and genuine interest among leaders of *New Care Models.* This would ensure progression of personality disorder pathways and resources. Arrangements may continue to exclude those individuals with significant and severe difficulties in their service planning. More positively, *New Care Model* developments builds upon existing provision, so opportunities may be available regarding developing formal partnership and alignment of existing Tiers 3 and 4 provisions across an *STP*. This is worth exploring but not without its challenges, as most *STP* areas have little Tier 3 provision and the only Tier 4 provision is currently regionally based. Further opportunities of a devolved *New Care Model* approach may be the ability to create more effective and complete pathways of care in a given *STP* locality.

Finally, from a regional perspective there has been the development of the PDS and Garrow House into a Tier 4 Personality Disorder NHS England commissioned service. This is a best practice model of Tier 4 given its adherence to the original specification and subsequent developments. The important lessons learnt have been the range of highly significant challenges in working with a group of women with a diagnosis of personality disorder who are likely to display 'high impact, high harm and high risk' behaviours. Such experiences reiterate that safe, effective and high quality Tier 4 services will require an innovative and creative clinical model and a range of developed and accessible Tiers 1-3 services to form a connected pathway.

Section 5: Secure Pathways

5.0 Forensic Outreach and Liaison Services

Forensic Outreach and Liaison Services (FOLS) are intended to be an important and efficient component of the pathway approach from medium and low secure services into the community. FOLS will offer:

- Consultation and liaison to local mental health services in the assessment and management of risk, to avoid where possible admission to secure services or where necessary expedite admission and treatment through secure services.
- Agreed arrangements will be in pace for regular engagement and collaborative working with respective local community forensic or community mental health services including the transition of individuals who no longer require specialist care.
- Consultation and liaison for MAPPA panels.
- Consultation and liaison to other services to reduce the need for admission into secure services, and where appropriate to provide expert advice on the management of individuals.
- Ongoing care and support for individuals requiring specialist interventions to address psychological and social care needs in order to reduce the risk of relapse and reoffending.

Transition and discharge from secure services to the community is recognised as a particularly difficult time for all concerned. FOLS aim to manage and facilitate the transition of high risk individuals with mental disorders, including personality disorder, through secure services into the community.

Analysis

Several local NHS Mental Health Trusts provide community forensic services within the region which have been established for a number of years. Services vary in resources and functions but are all provided within a multi-disciplinary context and attached to NHS secure services. The current community forensic service at South West Yorkshire Partnership Trust (SWYPT) named itself a FOLS in March 2019. It is anticipated other existing community forensic services will be transfigured to FOLS as part of the wider *New Care Model* reconfiguration during 2019 including current services within Leeds, Bradford, Hull and York. FOLS will be provided in all geographic locations and for all service users, regardless of gender or diagnosis, including individuals with a diagnosis of personality disorder.

A key task for FOLS will be to work safely and effectively with individuals who are admitted into and discharged out of secure services. This task is complicated by the pathway requirements of individuals within secure services and wider community on discharge including gender specific needs. Some community forensic services are likely to lack experience of working with individuals with a diagnosis of personality disorder given some services previously excluded individuals with this diagnosis.

This is especially the case regarding working with women, who may not have significant offending behaviours, but behaviours which present increased risk to the safety of self and others when residing within hospital environments. Therefore women may enter secure services but may not have distinct and significant forensic needs regarding offending behaviour. FOLS will need to work closely with services that are part of a personality disorder pathway and recognise that the context of experiencing secure services is often triggered by various complex cultural, social and clinical (substance misuse, trauma, personality disorder, mental illness) factors.

5.1 Secure Hospital Services

Secure services (high, medium and low provisions) provide care and treatment for individuals with mental disorders who are liable to be detained under the MHA, and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings. Individuals typically have complex mental disorders including personality disorder, which are linked to offending or seriously harmful behaviour

The core objectives of secure services are to assess and treat mental disorder, reduce the risk of harm others and support recovery and rehabilitation. Some individuals will have been in contact with the CJS and either been charged with or convicted of a criminal offence. Individuals admitted to secure services will be detained under the MHA and the decision to admit will have been based on a comprehensive risk assessment and detailed consideration of how the risk identified can be safely managed whilst in hospital via an Access Assessment.

Secure services are tasked with providing a comprehensive range of evidence-based care and treatment interventions delivered by practitioners with expertise in forensic mental health. A range of specialist treatment programmes are expected to be available, delivered individually or within groups. A key task of service provision is to safely transition individuals to the community, to a lower level of security, to prison or transfer out of secure services.

Secure services manage different levels of risk to others but often individuals with a diagnosis of personality disorder are likely to present a significant risk to self at times whatever the level of security and this is especially pertinent for women. Therefore high, medium and low secure services aim to provide a range of physical, procedural and relational security measures to ensure effective care and treatment whilst providing safety for the individual and others.

- High secure services provide care for those who present a grave and immediate danger to the public and who should not be able to escape from hospital.
- Medium secure services provide care for those who pose a serious risk to others and require physical security that prevents escape from hospital.
- Low secure services provide care for those who present a significant risk of harm to others and whose escape from hospital should be impeded.

5.2 Personality Disorder Secure Services

The NHS England service specification *Adult Medium and Low Secure Mental Health Services* (2017) identifies service requirements for individuals with a diagnosis of personality disorder:

- Specific training and competence for the workforce in working with individuals.
- Staff selection procedures to take into account ability to work with challenging behaviour.
- Services are psychologically informed, including the ward milieu, with a focus on opportunities for relating, maintaining optimism, boundaries and collaborative relationships.
- Sufficient attention paid to the environment as well as social interactions, to offer structure, support, validation, and opportunities to practice new ways of relating.
- Workforce to receive support, supervision and reflective practice opportunities.
- Holistic psychological formulation to drive recovery planning.
- Range of psychological treatments offered as described in NICE guidance.
- Continuity and consistency of relationships including during transitions from and to services.

Personality Disorder specific secure services are available throughout the region and within the 3 *STP* areas to a greater or lesser extent:

- **West Yorkshire and Harrogate**
  - Waterloo Manor Hospital in Leeds: Independent provider of low secure and locked rehabilitation services for women.
  - No personality disorder specific services for men at low or medium secure levels or women at medium secure.

- **South Yorkshire and Bassetlaw**
  - Cheswold Park Hospital in Doncaster: Independent provider of medium and low secure services for men.
  - Cygnet Sheffield: Independent provider for personality disorder specific services for women at low secure.

- **Humber Coast and Vale**
  - Humber Centre in Hull: NHS provider of medium secure services for men.
  - Stockton Hall Hospital in York: Independent provider of medium secure services for men and women
  - Garrow House in York: NHS commissioned service provided by Third sector service as a Tier 4 Personality Disorder and 'step-down' service for women.
  - No personality disorder specific services for men and women at low secure levels.

Analysis

This brief mapping of secure services demonstrates no *STP* has an existing secure pathway encompassing medium and low secure levels for women with a diagnosis of personality disorder. There is a medium and low secure pathway for men available at Cheswold Park Hospital in South Yorkshire and Bassetlaw. NHS England have also directed the Humber Centre provide their existing personality disorder specific service at low rather than medium secure, and in conjunction with Stockton Hall Hospital, will in the future provide medium secure services, offering a comprehensive pathway in Humber Coast and Vale. No personality disorder specific services are available for men in West Yorkshire and Harrogate at either low or medium secure levels. The impact for individuals with a diagnosis of personality disorder is significant in that they are often required to be admitted to both medium and low secure services outside of their local *STP* area, and sometimes the region, given the lack of local secure pathways. Independent providers play a significant role in providing secure services which may be due to their historical location within the region

The likely consequences of the number of out of area placements include challenges remaining in contact with care co-ordinators who are crucial in the planning of care including transition and discharge. This was made explicit in the interviews held with the *Clinical Leaders* across secure services who described a lack of professional contact and available community based services including housing as key obstacles to discharge planning. The distance involved of living in out of area secure services and being away from family, children and friends is also likely to contribute to a variety of frustrations toward services as well as the loss of vital social contact and protective factors for some individuals.

The following key themes were identified from a combination of *The Thematic Analysis and the Pathway Development Service* and the *Personality Disorder Strategy Report: Staff and Service User Focus Groups and meetings with Clinical Leaders* as well as the experience of the PDS.

- Lack of suitable and available step down services

The *Thematic analysis* and the *Staff and service user focus groups* revealed concerns which matched those of *Clinical Leaders* about the lack of suitable 'step-down' options from secure services. The experience of transition and discharge from hospital, particularly if there has been a long length of stay may feel *''too vast, and too big of a jump''* at times. The majority of the existing step-down services are mainly for women and provided by the independent sector via locked rehabilitation services apart from Garrow House which is available as a part of the regional women's pathway.

- Maintaining links with a personality disorder pathway

Maintaining links with other parts of the personality disorder pathway is a further challenge noted by the *Thematic analysis* and *Staff and service user focus groups* as it can be difficult to share information and plan pathways for individuals who have entered the independent sector, often out of area and region at times.

- *Resources*

Both the *PDS Thematic Analysis* and the *Staff and service user focus groups* noted the availability of resources within secure services in order to complete key service tasks can be variable. This may be a financial resource issue but also due to the difficulties in recruitment and retention of the required workforce across all key disciplines but especially nursing. This lack of nursing resource triggers the use of bank and/or agency staff members to a significant extent within services. This was highlighted by services users and staff members alike as potentially compromising the need for consistent care and treatment approaches.

Limited psychology resources in particular put a strain on service delivery including the provision of specific psychological interventions and the maintenance of a psychologically informed environment which are likely to reduce risk. This was especially pertinent for those individuals who have additional levels of complexity including trauma, substance misuse, self-harm who require access to psychology services.

- *Development of assessment and formulation*

The *Thematic analysis* highlighted the specific challenges encountered within secure services when working with individuals with a diagnosis of personality disorder. Firstly, some personality disorder specific services fail to recognise the importance of developing holistic based assessment and formulation as an initial key task before specific treatment needs are identified. Secondly, there appears to be a lack of a shared understanding of the individual within the clinical team including a clear plan on how best to address the individual's psychological needs. Psychologists may be allocated to deliver interventions discretely from the rest of the clinical team which are then disconnected from day today interventions. Understandably such issues were not always acknowledged by *Clinical Leaders* in personality disorder specific settings.

- *Effective therapeutic interventions*

The *Thematic analysis* described some psychologically based interventions offered to individuals may be relatively ineffective and therefore not helpful for individuals in progressing successful pathways. This was felt to be more likely for men with a diagnosis of Antisocial Personality Disorder within medium secure services. *Clinical Leaders* described difficulties in engaging and building motivation when working with individuals with this diagnosis. As a result, Access Assessments were now likely to focus on identifying levels of engagement and motivation as a key factor for admission.

The *Thematic Analysis* suggested there appeared to be a *"drive to treat"* individual's instead of recognising the first tasks are to create safety and containment and that outstanding treatment needs can be identified at an agreed later stage after assessments are completed. Secure services may find it difficult to acknowledge *''it might be enough"* and *"actually pushing people to engage in structured therapies is not the right time and it is unlikely to be successful''.* Individuals maybe expected to attend a range of individual or group work programmes, which are available to everyone rather than being individually tailored. Working within a group might be challenging for individuals whose core difficulties are related to their sense of self, identity and relationships with others. The importance of a psychologically informed process able to account for difficulties individuals encounter in such settings was identified.

- *Focus on relational safety*

Given the nature and purpose of secure services, it was suggested there may be a disproportionate focus on aspects of physical and procedural safety to the detriment of relational safety. This approach may see an over reliance on the use of restrictive interventions to manage an individual's distress and subsequent risk behaviours, especially self-harm if development of relationships are not an initial key task. This was supported by the experience of service users within the *Staff and service user focus groups* and staff members described difficulties in either attempting to reduce restrictive interventions or feeling unsafe when restrictive interventions had been significantly reduced. Some restrictive interventions were experienced as potentially re-traumatising for individuals and perceived as a form of punishment which significantly affected the therapeutic relationship and feelings of safety and containment.

- *Positive risk management*

The *Thematic Analysis Staff* and the *Staff and service user focus groups* recognised positive risk management as a significant intervention in order to safely manage risk and should be planned collaboratively. The use of Section 17 leave was described as an opportunity to develop positive risk management interventions. Unfortunately, it was sometimes the case that individuals struggled to attain leave for a variety of reasons including those related to culture and practice of clinical teams when assessing and managing risk and safety. It was suggested granting of leave may feel arbitrary at times and likely not to be part of a psychologically informed process with a clear purpose and with robust planning and monitoring arrangements. It was noted attaining approval for leave from the Ministry of Justice, for those individuals under restrictions, remained a lengthy process. This was likely to *"increase feelings of being stuck"* in secure services as well as staff members frustrations at a perceived lack of progress.

- *Specific treatment pathways*

Both the *Thematic Analysis* and the *Staff and service user focus groups* recognised the lack of identified short, medium and longer treatment goals and interventions to meet goals following admission to secure services. Individuals described feeling uncertain about the reasons why they were admitted to secure services. This included a lack of involvement and feedback in the Access Assessment process and clear communication regarding care and treatment interventions. Communication and information gaps in the admission process led individuals to feel frustrated, frightened and hopeless about their predicament.

Several *Clinical Leaders* acknowledged admission pathways, including assessment of needs and identification of treatment plans could be timelier. It was acknowledged progress had been made within services regarding development of specific psychological interventions such as CAT, DBT and the creation of treatment pathways. Not with standing, there appeared to be a lack of clarity in identifying and describing specific treatment interventions and pathways informed by assessment and formulation.

- *Transition*

Thematic analysis and *Staff and service user focus groups* described difficulties in the planning of transition and discharge from secure services. Service users described a lack of meaningful involvement in the process including the development of transition plans which acknowledged the psychological impact of leaving secure services. This apparent lack of involvement and ownership of the process was more likely to lead to disagreements within the clinical team. Subsequently, there is

frustration from all concerned and possible attempts by the individuals to delay discharge due to feeling unsafe during the transition period.

5.3 Gender Specific Pathways

➢ Women

The Yorkshire and Humber experience is pathways into secure services can be complex including gender differences. Whilst men are more likely to be involved in criminal proceedings and use of Part III of the MHA, women have less contact with the CJS and use of this part of the MHA as men.

The following table identifies all men and women within secure services by MHA status:

	Informal	Section 3	Section 37	Section 37/41	Section 47/49	Section 48/49	Total
Male	0	9	15	32	14	0	70
Female	1	20	4	10	3	2	40
	1	29	19	42	17	2	110

The women's pathway identifies the following characteristics and challenges:

- Significant multi-factorial risk factors arise within community settings which are serious and/or frequent including crisis and engagement difficulties.
- Lack of appropriate gender specific services and resources for women including psychological and social interventions within community settings at Tiers 1-4.
- Lack of community services and resources likely to lead to admission to local acute mental health services in order to contain immediate risk.
- Predictable escalation of risk whilst in hospital may lead to a lengthier admission and likely to lead to transfer to PICU which may be out of area.
- Subsequent referral to locked rehabilitation or low secure services likely given potential escalation of risk in PICU. Referrals are often made in the context that personality disorder specific services are better able to manage acute and chronic levels of risk and be of therapeutic benefit to the individual.
- Escalation of risk may continue in low secure services leading to medium secure admission.

At times of increased concern about a woman's safety, community services may feel unable to manage the level of risk, and view hospital as the safest option. Community services may not have the required clinical framework, intensive multidisciplinary approach or availability of resources and services to be assured that they can safely support and manage women especially when crisis occurs and risk increases. Community services may be working with women who are often unwilling or unable to access service interventions, or at least without the required additional support that may not be available. Given this context, women are likely to feel unsafe: i.e. the provision of a sense of psychological, physical or emotional containment from a therapeutic perspective unavailable.

Therefore the prospect of admission to a personality disorder specific hospital service is a more likely option for women given the lack of resources available within the community. Any extended hospital admission may inadvertently increase the possibility of 'step-up' into secure services given the difficulties of residing in hospital will remain. Women entering low secure services may be at risk

of further ‘step-up’ to medium secure services if the need for safety and containment is not met. Therefore pathway failures at all levels can often lead to women assessing a range of more restrictive services.

➢ Men

An increased number of men with a diagnosis of personality disorder are found in secure services as compared to women and a CJS pathway into personality disorder specific secure services appears more prevalent for men than women. Due to less contact with local acute mental health pathways, including remaining in custody and secure services for a significant amount of time, men appear to be less impactful on statutory mental health services in particular. ‘Step-down’ from secure services remains difficult for many men given the lack of options, especially at a local level within community based services.

The development of closer working arrangements with the Offender Personality Disorder pathway remains a challenge within the pathway and will be explored in the next section.

Section 6: Criminal Justice Pathways

The Offender Personality Disorder (OPD) pathway programme described in *The Offender Personality Disorder Pathway Strategy (2015)* is a jointly commissioned initiative between NHS England and the National Offender Management Service (NOMS). Its key aim is to provide a pathway of psychologically informed services for a highly complex and challenging offender group of men and women who are likely to have a severe personality disorder and who pose a high risk of harm to others, or a high risk of reoffending in a harmful way.

The central concept of the OPD programme is the delivery of a pathway of services for this complex group of individuals. The programme has developed distinct pathways for men and women offenders in recognition of the gender differences in nature of offending, life experiences, and the way personality disorder may present. Services for women are specifically designed and commissioned according to an appreciation of these differences and a strategy for women is currently in place.

The principles underpinning the programme:

- Shared ownership, joint responsibility with operations shared by NOMS and the NHS.
- Planning and delivery is based on a whole system pathway across CJS and NHS.
- Offenders with severe personality disorder with high risk of harm to others will be primarily managed within CJS.
- A formulation based approach is utilised.
- Treatment and management is psychologically and socially informed.
- Breakdown and failure is managed, reviewed and revised, and seen as opportunities to support future progression.
- Staff members have clarity of approach due to understanding the model and approach.
- Staff members are trained and supervised with the relevant knowledge and skills identified.
- Gender specific provision and training is in place.
- Offenders have clarity of approach and understand their role and responsibilities.
- Service user involvement is required across all aspects of service planning and delivery.
- Services will be developed in line with the evidence.
- Pathways will be evaluated.
- Clarity of outcomes to be identified which are explicit and measurable.

A key feature of the pathway framework is the commitment to a consistent and coherent process of an individual moving along a range of different CJS and health interventions which begin in community, moving through sentence, and a return to community at end of sentence. This forms a *'community to community'* pathway approach and very similar to the experiences of individuals within secure services.

HMP Garth Personality Disorder Service: Beacon Unit is a prison-based intervention service for male personality disordered offenders and forms a key component of the OPD Pathway Strategy. This service is especially relevant for those medium secure service providers working with individuals with a diagnosis of personality disorder. The service is located on a 48-bed wing within HMP Garth, a

Category B prison, and is delivered by a collaborative partnership between a specialist mental health provider (Mersey Care NHS Trust) and NOMS (HMP Garth).

The target group for this service is men meeting the following criteria:

1. Aged over 21 years.
2. Serving a sentence of imprisonment.
3. Assessed as presenting a high likelihood of violent or sexual offence repetition and high or very high risk of harm to others.
4. Likely to have a severe personality disorder.
5. A clinically justifiable link between the individual's personality disorder and their risk.
6. Evidence of motivation and ability to engage and benefit.

Individual offenders in the treatment phase of the personality disorder pathway are generally serving a determinate term of imprisonment of at least four years or an indeterminate sentence of any tariff length. They have complex needs consisting of emotional and interpersonal difficulties, and display challenging behaviour of a degree that causes concern in relation to their effective management.

The service principles include the following:

- Full integration of the service within existing services for personality disordered offenders and pathway management and planning (including secure services).
- Formulation as the basis of planning of, and intervention for, disorder and risk.
- Provision of individualised intervention and management programmes to improve psychological functioning and reduce risk of harm to others.
- Provision of the services within a continuous and enabling environment context.

Services for women are described in the *Brochure of Offender Personality Disorder Services for Women (2017).* Current services for women within prison, includes the Rivendell service at HMP/YOI New Hall in Wakefield. This service forms part of a treatment stage of the pathway for women offenders with a diagnosis of personality disorder. HMP New Hall also offers CARE, an accredited offending behaviour intervention for women in custody who have history of violence and complex needs which is trauma informed and gender responsive. Services in secure hospital include Rampton National High Secure Healthcare Service for women and Arnold Lodge Women's Medium Secure Unit Service.

The national community provision includes case identification, consultation, formulation, casework and workforce development within a principles based framework. This community provision includes Together Women, a Third sector organisation providing a Mentoring and Advocacy Service to support women's engagement and progression through a pathway of care and management. Together Women have been helpful in identifying the needs of women leaving secure services as part of the *Personality Disorder Pathway Strategy*. The aim of the Mentoring and Advocacy Service is

to reduce repeat reoffending and improve the overall health of women offenders with a diagnosis of personality disorder.

Together Women offer the following interventions:

- An allocated key worker and full needs assessment which informs the co-production of an individualised support plan.
- One to one emotional and practical support including accommodation, finances and benefits, children and families, education and training and motivation and social inclusion.
- Supported to access a variety of community interventions including women's hubs and services.
- Support is offered through flexible appointments, visits and telephone contact.
- Advocacy to help resolve issues, access services and ensure communication across agencies.

Analysis

It became apparent during discussions with *Clinical Leaders* as part of the *Personality Disorder Pathway Strategy*, that for personality disorder specific medium secure services, the Beacon Unit at HMP Garth was relatively unknown. Since the opening of the service, two medium personality disorder specific secure services within the region made approximately three referrals which were declined. Another provider had made no referrals but had some understanding what the service offered. No men had been referred for transfer to medium secure services from the Beacon Unit. Services that had referred individuals to the Beacon Unit were left feeling that those individuals with a diagnosis of personality disorder and a co-morbidity of mental illness and substance misuse were unlikely to be accepted to the service.

All three medium secure services within the region had not made further referrals and/or or developed pathway links. This appears to be a missed opportunity to create effective pathways for men with a diagnosis of personality disorder with offending behaviour between mental health services and the CJS.

A similar narrative is apparent for women's services. The one personality disorder specific medium secure service for women within the region were relatively unaware of the offender personality disorder pathway services available although Together Women were known by a low secure provider in West Yorkshire. It appeared no meaningful connection had been made between the various services. The Mentoring and Advocacy Service provided by Together Women has the potential to help meet the complex needs and aspirations of women awaiting discharge from secure services, and/or who have previous experience of secure services but who are currently living in the community.

A number of women will have had previous or current experience of personality disorder specific secure services but who have not offended; although will have similar needs to those women in prison. The needs of women may be linked to specific gender, social factors and experiences of trauma and therefore it is important to highlight and acknowledge a significant number of women

with a diagnosis of personality disorder may have similar core needs in relation to such experiences. The mutual sharing and development of good practice, including service provision and pathways, would be beneficial.

Section 7: Yorkshire and Humber Secure Service Provision

The Yorkshire and Humber region comprises most of Yorkshire as well as North Lincolnshire and North East Lincolnshire. It geographically encompasses coastal, rural and urban areas and has a population of 5.4 million at 2017 figures.

Statutory mental health services in the region are provided by 3 NHS Mental health Trusts in West Yorkshire and Harrogate; 1 in South Yorkshire and Bassetlaw; 2 in Humber Coast and Vale as well as a Health and Social Care CIC.

There are currently 17 CCG'S within the Yorkshire and Humber region. This consists of 6 within West Yorkshire and Harrogate; 5 within South Yorkshire and Bassetlaw and 6 within Humber Coast and Vale. This number is expected to significantly reduce in the near future.

The *Adult Secure Mental Health Service Review: Capacity Planning: All Yorkshire and Humber* was published 2018 by NHS England from information sourced in November 2017. This reviewed the Yorkshire and Humber population residing within medium and low secure services and formed the basis of a reconfiguration and reorganisation of the numbers and type of secure service beds required within the region aligned to their local *STP* area. This capacity planning has informed the ongoing repatriation of individuals into local *STP* areas.

Tables 1-3 identifies the number of Yorkshire and Humber male and female service users within high, medium and low secure personality disorder specific secure services within each STP area.

Table 1

High Secure	WY&H	SY&B	HC&V	Total
• Male	12	8	5	25
• Female	0	1	1	2
	12	**9**	**6**	**27**

Table 2

Medium Secure	WY&H	SY&B	HC&V	Total
• Male	13	12	12	37
• Female	6	4	2	12
	19	**16**	**14**	**49**

Table 3

Low Secure	WY&H	SY&B	HC&V	Total
• Male	9	10	14	33
• Female	10	9	9	28
	19	**19**	**23**	**61**

Key Points

- Individuals within high secure services need to have identified pathways into medium or low secure services throughout the region but particularly for men 2 STP areas.
- There is no current personality disorder specific medium and low secure services for men and medium secure services for women within WY&H yet 28 individuals will potentially require local STP services.
- There is no current personality disorder specific medium and low secure services for women within SY&B yet 13 women will potentially require local STP services.
- There are no current personality disorder specific low secure services for men and women within HC&V yet 23 individuals will potentially require local STP services.

Table 4 provides the total number of male and female service users within medium and low secure services by STP area.

Table 4

Total Medium &Low Secure	WY&H	SY&B	HC&V	Total
• Male	22	22	26	70
• Female	16	13	11	40
	38	**35**	**37**	**110**

Key Points

- Each STP area has a similar number of men and women within secure services.

Table 5 identifies men and women who are in or out of STP area

Table 5

Personality Disorder within whole region	Current Population		
	In STP Area	Out of STP Area	Total
• Male	22	48	70
• Female	16	24	40
	38	72	110

Key Points

- A significant number of men and women are not currently located within their local STP area and this number is particularly high for men.

Tables 6 and 7 identify those men and women from WY&H in low and medium secure services who are in or out of STP area.

Table 6

West Yorkshire & Harrogate : Total 38	Current Population		
	In Area	Out of Area	Total
Low Secure			
• Male	0	9	9
• Female	8	2	10
	8	11	19

Table 7

Medium Secure			
• Male	0	13	13
• Female	0	6	6
	0	19	19

Key Points

- 30 men and women within low and medium secure services from WY&H remain out of their local STP area so repatriation may be required especially for those men in low and medium secure services.

Tables 8 and 9 identifies those men and women from SY&B in low and medium secure services who are in or out of STP area

Table 8

South Yorkshire & Bassetlaw: Total 35	Current Population		
	In Area	Out of Area	Total
Low Secure			
• Male	8	2	10
• Female	5	2	7
	13	4	17

Table 9

Medium Secure			
• Male	4	8	12
• Female	2	4	6
	6	12	18

Key Points

- 16 men and women within low and medium secure services from SY&B remain out of their local STP area so repatriation may be required especially for those men in medium secure services.

Tables 10 and 11 identifies those men and women from HC&V in low and medium secure services who are in or out of STP area

Table 10

Humber Coast & Vale: Total 37	Current Population		
	In Area	Out of Area	Total
Low Secure			
• Male	2	12	14
• Female	0	9	9
	2	21	24

Table 11

Medium Secure			
• Male	8	4	12
• Female	2	0	2
	10	4	14

Key Points

- 24 men and women within low and medium secure services from HC&V remain out of their local STP area so repatriation may be required especially for those men in low secure services.

Table 12 identifies those men and women from Yorkshire and Humber who are currently out of the region

Table 12

Personality Disorder	Current Population		
	In Region	Out of Region	Total
• Male	55	15	70
• Female	26	14	40
	81	**29**	**110**

Key Points

- There are 29 men and women from the region currently within out of region secure services that may have specific needs that could not be previously met within their local area or region.

Table 13 identifies those men and women by STP area who are currently out of the region

Table 13

Personality Disorder	Current Population			
	WY&H	SY&B	HC&V	Total
• Male	6	3	6	15
• Female	6	5	3	14
	12	**8**	**9**	**29**

Key Points

- The out of region population are evenly spread between men and women and between all 3 STP areas.

It is acknowledged *Provider Collaboratives* will ultimately decide what secure services are required within each *STP* area. There may be the case that some personality disorder specific services remain commissioned on a regional basis e.g. women's services. This has been more closely discussed in Part 1 of the *Personality Disorder Pathway Strategy* as well as the on-going debate regarding the need for personality disorder specific inpatient services.

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