SCHEDULE 2 – THE SERVICES

Service Specifications

Service Specification No.	C08/S/a Draft 24/10/14
Service	Tier 4 Severe and Complex Personality Disorders (Adults)
Commissioner Lead	Maria Crowley
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

1.1.1   The World Health Organisation and the American Psychiatric Association have produced definitions of personality disorder. The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organisation 1992), defines a personality disorder (PD) as: 'a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption'. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association 2013) defines a personality disorder as: 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture'.

1.1.2   There are nine categories of ICD-10 personality disorder and ten categories of DSM-5 personality disorder.

1.1.3   The DSM clustering system is useful in distinguishing different populations of psychiatric patients. This system groups the subcategories of DSM-5 personality disorder into three broad groups or 'clusters' of personality disorder:

- Cluster A ('odd or eccentric'): paranoid, schizoid and schizotypal personality disorder.

- Cluster B ('dramatic, emotional or erratic'): histrionic, narcissistic, antisocial and borderline personality disorders.

- Cluster C ('anxious and fearful'): obsessive-compulsive, avoidant and dependent.

1.1.4   Personality disorders are common in the general population, and more so in

populations presenting to services. They occur with the following prevalence:

- *5% of people living in the community*
- *24% of primary care attendances in deprived areas*
- *30-40% of psychiatric outpatients and 40-50% of psychiatric inpatients*
- *50% of psychiatric emergencies*
- *50% of patients with medically unexplained symptoms*
- *57% of people who commit suicide*
- *50-70% of people in the prison population*
- *20-50% of people with personality disorder misuse substances.*

1.1.5 People with personality disorder present with a range of physical, mental health and social problems including substance misuse, depression, suicide risk, housing problems and longstanding interpersonal problems. Some commit offences and are periodically imprisoned. A few present a risk to others or serious danger. The impact of personality disorder on individuals, families and society is significant and requires a robust consistent response from a range of public and third sector agencies. Most people who present with personality disorders are cared for in primary and secondary care.

1.1.6 This specification is concerned with individuals who have a diagnosis of severe and complex personality disorder. 'Severity' involves a critical conjunction of the following five factors (DH 2009):

1.1.7 *Diagnosis*: the number of confirmed clinical diagnostic categories or diagnostic clusters represented, and dimensional scores of symptoms within each category.

1.1.8 *Pervasiveness*: the number of areas of somebody's life that are adversely affected gives an indication of functional impairment. This includes social, family and intimate relationships; occupational and educational stability; self-care; and recklessness and offending behaviour.

1.1.9 *Complexity*: common co-morbid problems include substance misuse, anxiety disorders, eating disorder, self-harm, brief psychotic episodes, depression, and an established diagnosis of bipolar disorder. Less common are head injury, learning disability, autistic spectrum disorder and schizophrenia spectrum disorders.

1.1.10 *Risk:* The risk of harm to self is common and often persistent and life-threatening in this group, with a high likelihood of completed suicide; high risk of harm to others is usually in those with a history of offending behaviour.

1.1.11 *Unmanageability*: failure of previous treatments can result in reluctance to engage in further programmes. In extreme cases this results in failure to establish therapeutic relationships with either staff or peers, and extreme destructive and self-defeating behaviour which cannot be contained in mainstream units.

1.2 Prevalence

1.2.1 It is unclear how many individuals in England have a diagnosable 'severe and complex' personality disorder. Initial indications (unpublished) are that this may be as many as 3000 individuals nationally which would indicate a national prevalence of 5.3 cases per 100,000 head of population.

1.2.2 The Tier 4 personality disorder (T4 PD) services described in this specification will work closely with local tiers 1-3 PD services to ensure that collectively the services are able to respond better to people with personality disorder; and to specifically

provide specialised time limited interventions in a day hospital or in-patient environment for the small number of individuals whose risks or needs mean they cannot be appropriately managed at the local tiers 1-3.

1.3 National Policy

1.3.1 Since 2003 the Government has targeted services for people with personality disorders for change and improvement through the 'Personality Disorder Development Programme' based in the Department of Health and Ministry of Justice. The work of the programme has included the development of new national policies to stimulate and guide local improvements:

- *Personality Disorder: no longer a diagnosis of exclusion (2003)*
  http://www.personalitydisorder.org.uk/assets/resources/56.pdf

- *Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework (2004)*
  http://www.spn.org.uk/fileadmin/spn/user/.pdf/Papers/personalitydisorders.pdf*

- *Reaching Out: An action plan on social exclusion (2007)*
  http://webarchive.nationalarchives.gov.uk/20070705125957/cabinet office.gov.uk/social exclusion task force/publications/reaching out

- *The Offender Personality Disorder Strategy (2010)*
  http://hlsweb.dmu.ac.uk/pgcpd/roh436/official-documents/Offender%20PD%20strategy.pdf

- *Beyond local services: commissioning and providing services for people with complex and severe personality disorders. (2008)*
  http://www.personalitydisorder.org.uk/assets/resources/167.pdf

1.3.2 The programme has also made significant investment in national pilot services to test ways of developing new local responses. This has seen the development of 11 community pilots across the country, 12 high intensity programmes for children and their families, medium secure forensic pilots and the Dangerous and Severe Personality Disorders programme within high secure hospitals and prison settings, later superseded by the Offender PD Programme. This has also included work in the prison based therapeutic communities.

1.3.3 Publication of clinical guidelines from the National Institute for Health and Clinical Excellence (NICE) on Borderline and Antisocial Personality Disorders (NICE, 2009) and publication of commissioning guidelines: Recognising complexity: commissioning guidance for personality disorder services (DH 2009) has placed further emphasis on the need to radically transform the way services for this population are commissioned.

1.3.4 Workforce development has seen investment in the development of a national training programme, the Knowledge and Understanding Framework (KUF) with training from awareness level through to Masters level being available across services and agencies.

1.4 Evidence Base

1.4.1 The evidence base for Tier 4 Personality Disorder (T4 PD) and specialised Tier 3 Personality Disorder (T3 PD) Services is limited. A review conducted by Crawford and colleagues in 2008 found that empirical studies to determine the populations

being treated in residential services and specialised T3 PD services used diverse measures of severity, making it difficult to establish a 'severity characteristic' that reflected each population.

1.4.2 The defining characteristic of people referred to dedicated services appears to be the incapacity of mainstream services to manage care and effect change. The predominant patient group are those with a diagnosis of Borderline Personality Disorder. A proportion of people with severe borderline PD have a strong tendency toward psychiatric help seeking, demanding behaviour and social disruption, potentially predisposing them to exhausting other services.

1.4.3 There is an emerging evidence base for the effectiveness of a range of interventions delivered in the community. Dialectical behaviour therapy (Linehan et al 1993 Naturalistic follow-up of a behavioural treatment for chronically parasuicidal borderline patients. Archives of General Psychiatry) and mentalisation based therapy (Bateman & Fonagy 2008, 8-Year Follow-Up of Patients Treated for Borderline Personality Disorder: Mentalization-Based Treatment Versus Treatment as Usual, American Journal of Psychiatry) have demonstrated effectiveness in intensive outpatient settings over medium to long term treatment (12-18 months). However the evidence base is currently inadequate to enable matching treatment to personality characteristics and other patient variables. In addition the therapeutic challenges of work in T4 PD services are different to those in T3 PD services, where trials have been carried out. Single model interventions are unlikely to be sufficient for the T4 PD patient group, and services will draw on a range of therapeutic approaches according to clinical need.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.1.1 The service will deliver high-quality, individualised, pathway-based care packages. The aim will be to provide a therapeutic programme in order at the end of treatment to help individuals back into the care of local services, whilst keeping any established risks minimal. Least restriction principles should be applied at all points

2.1.2 Services will be tested against measureable, service-wide, outcomes. These will include high levels of service user and carer satisfaction, and minimised levels of adverse incidents and complaints. Future work will be required to track outcomes across the care pathway.

2.1.3 Services will be expected to report separately to organisations concerned with the quality and safety of services, including the Royal College of Psychiatry College Centre for Quality Improvement and the Care Quality Commission.

2.1.4 Process indicators and outcome measurements will include:

<u>Staying healthy (NHS outcome framework domain 1)</u>

<u>Process indicators:</u>

1   Registration with a GP

2   Registration with a dentist

3   Monitor prescribed medication use

<u>Outcome indicators:</u>

1   Participation in health screening programme

2   Individual needs assessment and care plans on physical healthcare

3   Number of emergency health care attendances

<u>Mental health recovery (NHS outcome framework domain 2)</u>

<u>Process indicators:</u>

1   Occupied bed days/length of stay for patients
2   HoNOS (Health of the Nation Outcome Scale)
3   MHMDS (Mental Health Minimum Data Set)
4   Mental Health Quality Dashboard

<u>Outcome indicators:</u>

1   Length of time from discharge to readmission

2   Reduction in self harm and suicidal acts

3   Referral rates to emergency services (including A&E, Ambulance Service and police)

4   Reduction in prescribed medication use

5   Reduction in violent incidents

6   Participation in therapeutic programmes

7   Complaints

<u>Enhancing quality of life (NHS outcome framework domain 2)</u>

<u>Process indicators:</u>

1   Monitoring and learning from serious incidents

2   Care plans identifying individual risks

3   Crisis care plans, identifying early relapse indicators and interventions

Outcome indicators:

1. Use of Section 17 leave

2. Patient takes active part in care planning

Helping people to recover from episodes of ill health (NHS outcome framework domain 3)

Process indicators:

1   Number of referrals

2   Time to assessment, time to commencement of treatment

3   Early unplanned termination of treatment

4   Length of stay

5   Bed occupancy and day programme take up

6   Mental Health Quality Dashboard

Outcome indicators:

1   Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (14 point mental wellbeing)

2   All patients will be routinely assessed by the use of SCID-2 or IPDE

3   EQ-5D

4   Work and Social Adjustment Scale (WSAS)

Recovery from drugs and alcohol problems (NHS outcome framework domain 3)

Process indicators:

1   Percentage of patients whose assessment includes drug and alcohol screening

Outcome indicators:

1   Percentage of patients with a jointly agreed care plan to manage alcohol and or drug dependence

2   Percentage of patients assessed for drug and or alcohol use as part of a physical health assessment and where a drug and or alcohol dependence has been identified.

Ensuring people have a positive experience of care (NHS outcome framework domain 4)

Process indicators:

1   Obtaining real time feedback on service user and carer experience.

2   Patient participation in service improvements and evaluation

3   Patient participation in workforce recruitment

<u>Outcome indicators:</u>

1 Service user satisfaction response

2 Carer, family and friends satisfaction responses

3 Percentage of service improvements made in relation to quantitative and qualitative service user and carer feedback

4 Percentage of service users determining own outcome goals

5 Evidence of on-going service user improvements

<u>Treating and caring for people in safe environments (NHS outcome framework domain 5)</u>

<u>Process indicators:</u>

1 Running of unit in a structured environment

2 Use of a personality disorder clinical framework

3 Use of a recovery tool

4 Evidence based treatment interventions

<u>Outcome indicators:</u>

1 Family/Carer satisfaction levels

3. Scope

3.1 Aims and objectives of service

3.1.1 T4 PD services will provide specialist and intensive provision beyond that which can be provided within either local specialist (T3 PD) services or other local mental health services including acute inpatient facilities. Whilst patients would not meet requirements for secure services (i.e. present a significant risk of harm to others) it is expected that they will present with complexity and significant risk issues which prevent safe and effective engagement with local services.

3.1.2 Although the primary diagnosis will be personality disorder, many patients are likely to have significant comorbid conditions such as substance misuse, eating disorders and transient psychoses.

3.1.3 The function of the T4 PD service is:

- to provide assessment for people diagnosed with personality disorder

- to offer direct clinical care for people diagnosed with personality disorder within a clinically coherent personality disorder specific framework, and in a structured environment

- to work closely with local personality disorder pathways and services which will provide suitable treatment and care management on leaving T4 PD provision and to reduce the likelihood of people requiring admission to T4 PD services.

3.1.4 This means that services not only need to provide inpatient treatments, but must work closely with local services to ensure a safe and coherent care pathway.

3.1.5 The service will:

- Provide effective and coherent residential and day services to deliver safe care and treatment for individuals with severe and complex personality disorders, who due to reasons of risk and complexity are unable to be suitably managed within local T3 PD services or generic mental health services.

- Provide focused time limited outreach services to ensure an integrated care pathway across tiers 3-5.

- Support patients to manage any remaining difficulties independently in order to achieve recovery

- Ensure all patients are treated in the least restrictive setting, consistent with safe practice

- Liaise closely with T3 and T5 services to ensure smooth and timely step up and step down procedures

- Inform future commissioning arrangements by the provision of regular and detailed information regarding needs and prevalence of complex personality disorder populations.

- Provide regular outcomes data as detailed in section 2 of this document

3.1.6 As part of the PD pathway, the service will:

- Collaborate with local T3 services, offering specialist assessment, consultation and support to those services.

- Offer intensive specialist therapy or other input for individual people in T3 with a particular need.

- Collaborate with services in T5 and T6 (high secure services) to ensure people leaving those services are prepared for and supported through a suitable reintegration into the community.

- Be a centre of support and advice for clinicians across the Provider Network.

- Support people who use PD services to have a voice in the planning and development of those services

3.2 Service description/care pathway

3.2.1 T4 PD services provide specialist and intensive provision beyond that which can be provided within either local specialist T3 PD services or other local mental health services including acute inpatient facilities.

3.2.2 Many people with a diagnosis of personality disorder are admitted to local acute psychiatric units due in the main to risk of severe self-harm and/or suicide. It is not anticipated that T4 PD services will replace these local services, but will act as an additional resource to provide expert treatment and support to people with these diagnoses.

3.2.3 The function of the T4 PD service is to provide direct clinical care delivered in line with a clinically coherent personality disorder specific framework and within a well structured environment. This may involve stabilisation, preparation for local treatment, or specialist treatment with the intention of promoting recovery. A clinically coherent framework involves all aspects of provision and requires the unit to apply a single philosophy of treatment to the physical environment, the clinical

approach, and the relationships between the staff and the patients.

3.2.4 The service will comprise the following elements:

- Provision of timely and appropriate assessments in a range of settings, for access to T4 PD in-patient beds for individuals with personality disorder.

- Provision of specialist assessments for those people whom referrers consider to require interventions from T4 PD in-patient services.

- Provision of specialist interventions which are effective in reducing risk and which enable the individual to manage their presenting problems.

- Provision of specialised in-patient treatment in a safe and effective therapeutic environment

- Provision of close liaison with local teams and networks to ensure seamless transition between the specialised and local elements of the pathway

- Provision of transitional support to help patients re-integrate into local pathways/services.

- Service user involvement as a key component in all aspects of the specialised pathway

- Family and friends/carer liaison when appropriate

- Provision of information and intelligence to inform on-going population needs assessments and commissioning plans for the personality disorder population.

3.2. 5 Service Standards

- Formal written referrals will be used that are sent to the referring team within 48hours of completion of assessments.
- Access assessments must be undertaken by qualified professionals and will be required to meet the acceptance criteria outlined in 3.7.1 of the specification.
- Assessments must identify the need for a hospital admission
- Identify the level of urgency
- Identify the level of risk
- Identify further initial assessment requirements
- Provide advice and recommendations to the referring team on the care and management of individuals should admission not be recommended.
- The assessment must outline the reasons for admission, the treatment interventions required and specify outcome measurements.
- The assessment must include a physical health needs assessment and an accurate medical history to facilitate the medicines reconciliation process.
- Mental health needs assessment to include psychiatric, nursing, psychological and social circumstances reports.

3.2.6 Equity of access to services

The services provided will uphold equality and diversity legislation and will not discriminate on the basis of the following characteristics:

- Ethnicity

- Legal status (e.g. asylum seekers)

- Disability

- Gender – Services need to demonstrate that the needs of male and female service users are met, and can develop service provision to appropriately meet these needs.

- Age

- Sexuality

- Religion

- Other disadvantaged communities including people who are excluded due to education or skills levels, unemployment or where they live.

3.3 Service description

3.3.1 Treatment Phases

3.3.2 The personality disorder treatment programme can be described in four phases:

- Phase 1: Engagement and Stabilisation

- Phase 2: Assessment and Preparation

- Phase 3: Definitive Therapy

- Phase 4: Rehabilitation and Recovery

3.3.3 When is T4 PD required?

3.3.4 For all but the most severe cases, treatment can be undertaken in local T3 PD services, but these local facilities may not be able to manage patients who (1) live very chaotic lives, are unwilling to accept help from local services, or become involved in escalating complaints (2) have comorbidities such as substance abuse, learning difficulties or autistic spectrum disorders (3) become so emotionally unstable when starting therapy that they pose too great a risk to treat as outpatients (4) cannot tolerate a planned ending of therapy, and become increasingly disturbed. See section 3.7.1 Acceptance criteria for more detailed information.

3.3.5 T4 PD services will be the primary resource from which support for these problems, which cannot be solved by local services, is available. Some of this will need to be made available through liaison and support for T3 PD services.

3.3.6 The role of residential treatment

3.3.7 For the most chaotic and hard to help patients, T4 PD services will offer short-term residential engagement and stabilisation as part of a longer-term treatment pathway – but they will also offer advice and support to T3 PD services about the limits of what can be achieved by a reasonable level of local intervention. For those whose severity is characterised by comorbid problems, T4 PD services will be able to offer consultation, and services will be expected to develop specialisations to allow cross referrals (for example, a service may have a specialist facility for PD comorbid with eating disorders, learning disability, or somatoform disorders). The major treatment role for T4 PD services will be for those patients whose safe treatment requires a higher level of containment than can be provided by local non-residential programmes, either through higher intensity and frequency of therapeutic input, or through the specialist residential therapeutic environment. This may be as a short-term preparation or adjunct to difficult phases of treatment, or for long-term definitive

treatment programmes (a year or longer).

3.3.8 Service Standards

- Following a decision to admit, an appropriate 'first 72 hours' safety transition care plan will be agreed.

- All patients will have a care plan that outlines the treatment programme based on recognised clinical interventions, eg Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), Cognitive Analytical Therapy (CAT), group analytical approach and therapeutic community models (TC), Mentalisation based on therapy (MBT)

- Care plans should reflect, risk behaviour and reduction over the course of treatment. When risks are identified, there should be an associated documented risk management plan in place that shows how the risks are being addressed and evidences patient consultation and multidisciplinary engagement in the process.

- Services are required to use a range of clinical outcome measurement in consultation with patients that will commence prior to an admission, throughout the period of treatment and at the point of discharge.

- The care plan must include progress indicators that focus on the nature and degree of mental disorder, and its relation to risk.

- All patients must have regular, at least 6 monthly physical health assessments and access to a range of treatments as clinically indicated.

- Services will demonstrate that real time feedback is obtained from patients and relatives on their care and treatment, including safety and action is taken on areas of dissatisfaction.

- Services must evidence that patients have access to an independent mental health advocacy service.

3.3.9 Access Assessment procedures shall be developed in partnership by the commissioner and providers. This should build on current good practice that exists locally.

3.3.10 Workforce requirements

- The clinical team required to undertake this work will need be drawn from a mixture of mental health professional and other backgrounds (e.g. psychiatry, psychotherapy, nursing, psychology, social work, occupational therapy and social therapy, including ex-service users), and have a high level of expertise and experience in specialist personality disorder work.

3.3.11 Service Standards

- The service will be required to recruit an appropriately skilled multidisciplinary team with the skills and competencies to deliver a wide range of treatment interventions to include psychosocial and psychological interventions in acute and community settings. Each service needs professionals who can take Responsible Clinician (RC) responsibility.

- Staff will be expected to hold core generic therapeutic competencies and have had access to appropriate training in the specialist treatment of PD including the

Knowledge and Understanding Framework (KUF).

- Services will be expected to have a workforce that is trained and competent to deliver psychological evidence-based treatment interventions.

- All clinicians will be required to demonstrate an understanding of severe and complex personality disorder and have skills in the identification, assessment and treatment of severe personality disorder.

- All clinicians will be required to have individual formal supervision on a monthly basis that supports reflective practice and assists staff to manage anxiety and deal with conflict.

- Staff will have access to evidence based training and regularly attend reflective practice, clinical supervision and appraisal sessions.

- Providers will be required to have a robust framework in place for the recruitment and retention of staff, and use job descriptions and person specifications that outline the core skills, competencies and professional qualifications required to provide care for people with complex and severe personality disorder.

- Provides are required to evidence use of a competency framework in providing personality disorder care and treatment. The nationally developed Knowledge and Understanding Framework (KUF) and or 'A competency framework of psychological interventions with people with personality disorder' are recommended for use by all services.

- Provides are required to have a training register that collects all of the data on all staff training.

- Services will be expected to participate in peer review schemes which have established quality benchmarks applicable to T4 PD Services, eg Community of Communities and Enabling Environments.

3.3.12 Treatment models

The 2009 NICE guidelines for Borderline and Antisocial PD cite the lack of specific evidence for particular models of therapy, but support the principle that as evidence accumulates, practice should develop accordingly. The guidelines emphasise the value of non-specific therapeutic factors, such as service users being involved about decisions about treatment, the need for an optimistic approach, and therapy programmes being clinically coherent and well-understood by those involved in them. Some of these factors, such as the 'quality of therapeutic environment', are already part of relevant quality improvement programmes, which T4 PD services will be expected to participate in (see section 4.2.1). Accordingly, people requiring specialist T4 PD provision should be treated in a psychologically informed or therapeutic environment that can provide skilled interventions and treatment models, in combination with psychosocial interventions.

3.3.13 T4 services will provide residential treatment and day treatment with 24 hour cover.

3.3.14 The nature of T4 PD services

3.3.15 The major role of these specialist services will be detailed assessment and treatment planning for the most complex cases. They will operate an inclusive policy

in line with the policy guidance 'No Longer a Diagnosis of Exclusion' (2003).

3.3.16 The assessment function in T4 will be led by clinicians with a high level of experience and expertise in the field working as part of a multidisciplinary team. Treatment planning will result in the production of 'complex care plans' where responsibility will:

a) remain with referring teams if specialist treatment in T4 PD is not planned;

b) be shared between the T4 PD service and, for example, a local T3 PD service or a local drugs and alcohol service; or

c) be taken on by the T4 PD service.

3.3.17 The service will provide residential, day and outpatient treatment programmes in line with individual need.

3.3.18 Patient and carer involvement has become an essential component of contemporary health policy. This is particularly the case in mental health services where service user involvement has been instrumental in driving service change, and particularly important within specialised services for people diagnosed with personality disorder. It is essential therefore that the T4 PD services involve service users at all levels within the service either through the direct employment of service user consultants (experts by experience) or through other structured means.

3.3.19 The service should provide education and support programmes for families and carers.

3.3.20 T4 PD services will be expected to develop and participate in on-going teaching and training, service evaluation and research activity which will inform both clinical effectiveness and future commissioning.

3.3.21 All T4 PD services will provide:

- Collaborative care pathway planning, working closely with local services to help patients maintain their links to the community, supporting the ownership and commitment of local services, and ensuring smooth transitions as patients develop/progress.

- Liaison support, including consultation, liaison and advice to local services to support workforce development and improve local responses and mainstream service access for PD patients.

- NICE guidelines (CG 77, 78) note that it is good practice when considering inpatient care to actively involve the patient in decision-making. This ensures the decision is based on an explicit joint understanding of the potential benefits and likely harm that may result from admission. It is important to agree the length and purpose of the admission in advance and to ensure that when, in extreme circumstances, compulsory treatment (under the Mental Health Act) is used that interventions are organised in such a way as to facilitate the patient to make choices about their therapy at the earliest Opportunity. All service users will have an individual care plan, collaboratively developed, from the assessment of their needs and which sets out a range of therapeutic, recreational and rehabilitative plans to address their needs. Families and carers should be involved with the consent of the service user, as should appropriate professionals from elsewhere. T4 PD services will actively help service users to

stay connected with their homes, families and neighbourhoods where appropriate.

- It is likely that the initial role of the T4 PD service will be to offer sufficient containment through higher intensity and frequency of therapeutic input, or through the specialist residential therapeutic environment, to allow the service user to progress to the point where they are able to make decisions about engaging in therapeutic work.

- Effective transitional care services that consider the special needs of young adults making the transition from children's to adult services.

Diagram 1
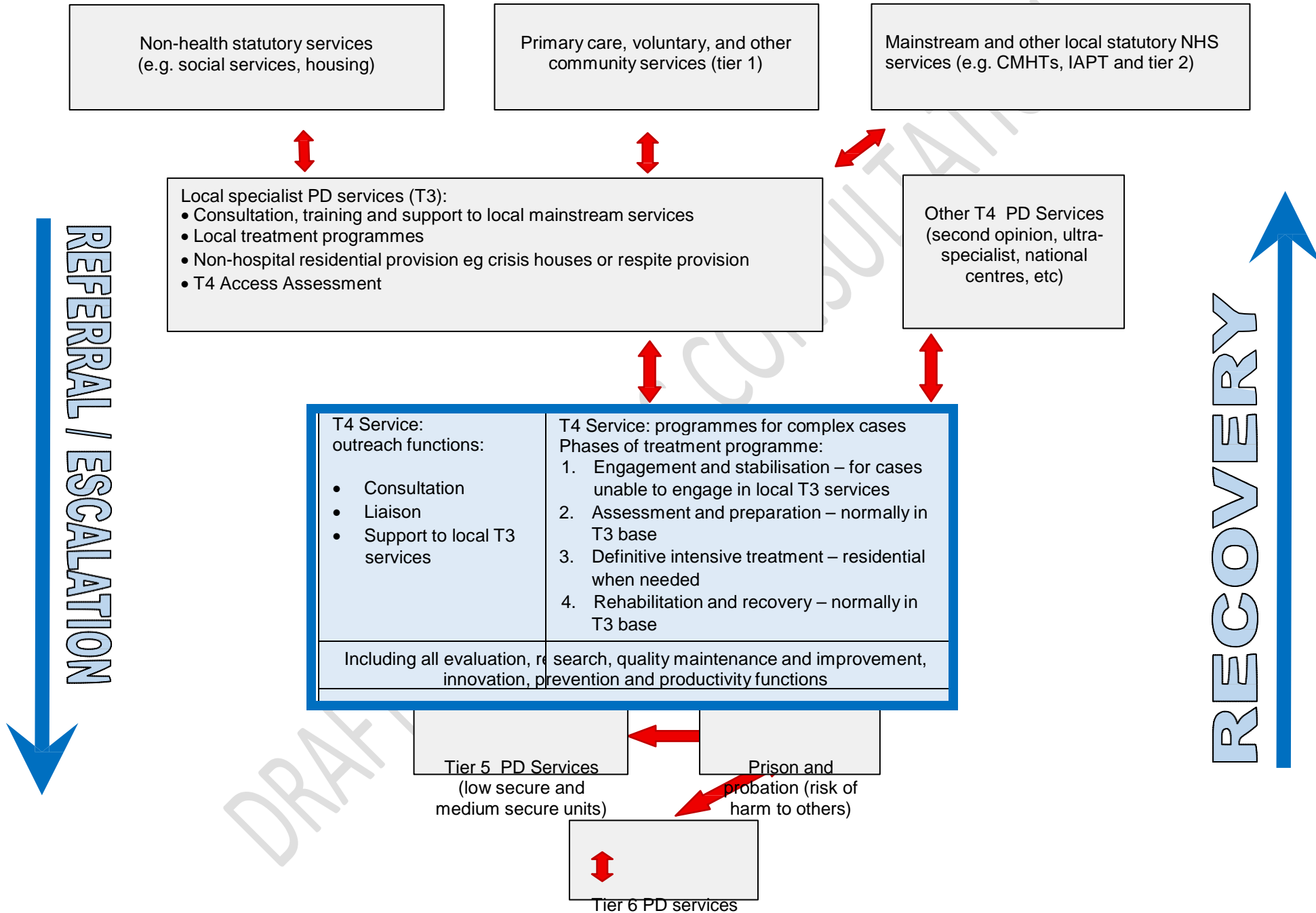
Non-health statutory services
(e.g. social services, housing)

Primary care, voluntary, and other
community services (tier 1)

Mainstream and other local statutory NHS
services (e.g. CMHTs, IAPT and tier 2)

Local specialist PD services (T3):
- Consultation, training and support to local mainstream services
- Local treatment programmes
- Non-hospital residential provision eg crisis houses or respite provision
- T4 Access Assessment

Other T4 PD Services
(second opinion, ultra-
specialist, national
centres, etc)

REFERRAL / ESCALATION

RECOVERY

T4 Service: outreach functions:	T4 Service: programmes for complex cases Phases of treatment programme:
• Consultation • Liaison • Support to local T3 services	1. Engagement and stabilisation – for cases unable to engage in local T3 services 2. Assessment and preparation – normally in T3 base 3. Definitive intensive treatment – residential when needed 4. Rehabilitation and recovery – normally in T3 base
Including all evaluation, research, quality maintenance and improvement, innovation, prevention and productivity functions	

Tier 5 PD Services
(low secure and
medium secure units)

Prison and
probation (risk of
harm to others)

Tier 6 PD services

(high risk of harm to others)

3.4 Care pathways

3.4.12 The PD care pathways for patients are mapped in Figure 1 (Tiers of provision)

3.4.13 The T4 PD in-patient service is required to be outcome focussed and it is essential that local services remain in close contact with both the patient and the provider of services to provide an integrated pathway.

3.4.14 Specialist T4 PD services are a part of the treatment and care continuum for that individual, it is therefore essential that local services remain full partners in the care and treatment their service user receives. The T4 PD in-patient service is expected to plan the discharge for each individual service user from the outset to manage the transition smoothly and seamlessly during the discharge process. Planning for discharge and liaison with the referring agency should be commenced at the point of referral in consultation with the patient to support effective pathway management. As part of this process the referring community team should remain involved with the patients care. As far as possible admissions will be undertaken with the patient's consent. If the patient does not consent they may be detained under the Mental Health Act 1983, as amended 2007. If the patient lacks capacity to consent, and the Mental Health Act is not considered appropriate, consideration will need to be given as to whether they are being deprived of their liberty (Mental Capacity Act (MCA), 2005 & Deprivation of Liberties (DOL), April 2009). If this is the case the managing authority (provider) will need to inform the supervisory authority and appropriate action will be taken to assess whether or not the service user's liberty is being deprived.

3.4.15 Partner service network in the care pathway

- Local services remain full partners in the care and treatment for the service user while in T4 PD care to manage the transition back to local services smoothly and seamlessly.

- To this end, the outreach functions of T4 PD services will include consultation, liaison and support to local T3 PD services.

- Local T3 services will play a key role in referral to T4, both in terms of assessment and ensuring that local resources have been appropriately accessed. The majority of referrals would be expected to come from T3 services. The T4 outreach service will play a key role in arranging and 'brokering' pathways back into local services, and providing consultation to local teams to help with the transition.

Figure 1 – Tiers of provision diagram
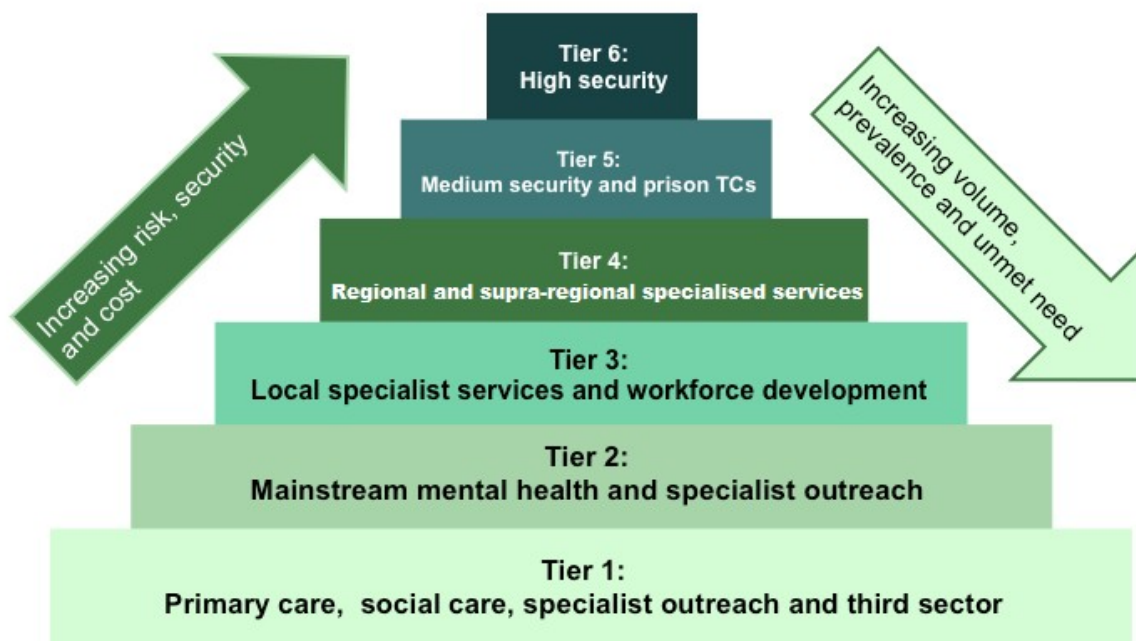
3.5 Referral processes and sources

3.5.1 Referrals from community settings (below T4 PD) can only be made by local T3 PD services in consultation with the local mainstream mental health service. In areas without T3 PD provision, the mainstream mental health provider will nominate those with suitable expertise to make the referrals.

3.5.2 The Outreach T4 PD Service will assess referrals and manage admissions to the inpatient unit, liaising with partner pathway agencies, in accordance with agreed access assessment protocols.

3.5.3 Where in-patient admission or intensive day provision for T4 PD is not required the T4 PD Outreach Service will provide Case Consultation and in some cases will co-work with local teams to ensure that local capacity is enhanced and that an appropriate community package is delivered.

3.5.4 Discharge/care pathway and recovery planning will be included in the admission process.

3.5.5 All referrals to a T4 PD Service must be accompanied with a comprehensive Access Assessment which will be used to determine the appropriateness of receiving T4 PD specialist input. Referring clinicians will be expected to use the Thames Valley severity tool available at http://www.personalitydisorder.org.uk/news/wp-content/uploads/Severity-questionnaire.pdf Where patients score 7 or below, it is expected that the

local service or T3 PD service will lead on the patients Care Programme Approach (CPA) with input and support from the T4 PD service as appropriate.

3.5.6   Normally patients referred for assessment should be over 18 years of age, however it is recognised that there will need to be interface between the T4 PD Outreach service and T3/4 Child and Adolescent Mental Health Services (CAMHS) in complex cases where emerging personality disorder is present in those under 18 years of age who may need to transition to adult services

3.5.7   Care planning

- The T4 PD team will hold enhanced CPA responsibility jointly with the local service but taking the lead for initiating reviews and involving local services at all stages in care planning.

- The T4 PD team will invite the commissioner to attend key review meetings to support care pathway planning

- The care co-ordinator from the local clinical team is expected to attend and will be formally invited to all review meetings to help expedite progress along the care pathway.

- Towards the end of treatment, the T4 PD (Outreach) Service provider will be required to work closely with local services to expedite discharge, ensuring local services are in place to support the transition back to community services.

- The T4 PD team will be responsible for coordinating service user's legal status as informal patients, as deprived of liberty (MCA 2005 and DOL 2009), or detained (MHA 1983, as amended 2007) with the relevant agencies, and partner services for recovery step down planning.

3.5.8   Service Standards

- Services will need to provide evidenced awareness and use of recovery care plans using recovery focused tools and approaches so that individuals are as fully involved as possible in understanding their needs, monitoring their progress and engaged in developing collaborative care plans based on outcomes.

- All patients will have a care plan reflecting a recovery and outcome based whole care pathway approach and will include transition and engagement with the patient and carer and family where agreed.

- All patients will have a crisis management plan that must be shared with the referring agency, GP and other identified agencies via the CPA process.

3.6   Population covered

3.6.1   The service outlined in this specification is for individuals ordinarily resident in England*; or who are the commissioning responsibility of NHS England. (as defined in: Who pays? Determining responsibility for payment to providers. Rules and guidance for clinical commissioning groups).

http://www.england.nhs.uk/wp-content/uploads/2013/08/who-pays-aug13.pdf

* Note: for the purposes of commissioning health services, this EXCLUDES individuals who, whilst resident in England, are registered with a GP Practice in Wales, but includes individuals resident in Wales who are registered with a GP Practice in England.

3.6.2 Specifically, this service is for adults (18+) with severe and complex personality disorders. This group is defined as patients who have:

- more severe and complex needs than can be met through local specialist service provision (described as 'T3')

- and who need in-patient or other time limited intensive services but who do not fall into the forensic/secure category i.e. patients with PD who present serious risk to others and need treatment in a secure setting

3.7 **Any acceptance and exclusion criteria and thresholds**Acceptance criteria

a) Score of 8, 9, or 10 on Thames Valley severity tool , available at http://www.personalitydisorder.org.uk/news/wp-content/uploads/Severity-questionnaire.pdf

b) AND not responding to T3 specialised PD service interventions, with or without admissions to general psychiatric wards

c) AND one or more of:

- High chronic risk of suicide or accidental death

- Co morbid psychiatric disorders or other conditions (such as head injury or learning disability) that makes management difficult in normal psychiatric settings

- Cycle of minor offending behaviour resulting in repeated short prison sentences or probation orders, or repeated admissions to psychiatric units without significant long term improvement

- Intractable healthcare seeking or self-destructive behaviour resulting in significant burden on acute services and significant threats to their health and wellbeing

- At significant risk of on-going exploitation or abuse in present situation

- Individuals being released from medium or low secure forensic settings who need a safe setting and specific personality disorder treatment without forensic levels of security.

- In exceptional circumstances, when otherwise agreed between T3 PD and T4 PD experts.

3.7.2 Exclusion criteria

3.7.3 T4 PD Service Provision will not be available where an assessment indicates a need for

- Forensic/Secure services due to a significant risk of harm to others

- Brief (less than one month) admission for the purpose of containment

during crisis

- Service for those aged less than 18 with Emerging Personality Disorder
- Service specific for the need of people with moderate to severe learning disability

3.8 **Interdependencies with other services/providers**Interdependencies with other services/providers

- Community mental health services
- T3 local specialist personality disorder services
- Criminal Justice system
- Social services
- Multi-agency Public Protection Panels (MAPPA)
- Housing
- Voluntary and non-statutory agencies
- Children, families and young people services
- Other Specialised Mental Health Services (e.g. Specialised Eating Disorder services)

3.8.2 Related services and other relationships

- Regional PD networks
- Service User Groups/Organisations
- Carers organisations
- Case Managers
- The service is expected to have protocols in place to enable clinical information sharing with other agencies as appropriate which are underpinned by Caldecott principals and information governance structures.

3.8.3 Co-located Services

Co-location is not essential to the provision of T4 PD services. There is no established shared benefit leading to reduction of costs from co-location. The T4 PD In-patient service should have a risk management strategy covering therapeutic and environmental provisions, which will include either adequate staffing to manage risk locally, or interdependence with nearby mental health units and emergency provision to allow for shared support services and provision of support should it be required in an emergency situation.

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

T4 PD services are defined in The Manual for prescribed specialised services. Published on the NHS England website:

http://www.england.nhs.uk/wp-content/uploads/2012/12/pss-manual.pdf

This specification should be read in conjunction with and ensure compliance with:

- NICE Guidance for treatment of borderline personality disorder and antisocial personality disorder (CG77 and CG78, NICE 2009) http://www.nice.org.uk/CG78 and http://www.nice.org.uk/CG77

- Personality disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder. (DH 2003). http://www.personalitydisorder.org.uk/assets/resources/56.pdf

- Recognising complexity: Commissioning guidance for personality disorder services (DH 2009) http://www.personalitydisorder.org.uk/assets/resources/173.pdf

- Behavioural and Cognitive Treatments: Guidance for Good Practice (CR68, Royal College of Psychiatrists, 1997). www.rcpsych.ac.uk files pdfversion cr   .pdf

- The National Suicide Prevention Strategy http://bit.ly/14ZEXTQ

- NICE guidance, Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (2005). http://www.nice.org.uk/nicemedia/pdf/cg025The Mental Health Act 1983 (as amended 2007), Mental Capacity Act 2005.

- The Personality Disorders Capabilities Framework (NIMHE 2003) http://www.spn.org.uk/fileadmin/spn/user/*.pdf/Papers/personalitydisorders.pdf

4.2   Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.2.1   The Royal College of Psychiatry College Centre for Quality Improvement (CCQI) has established two schemes which have established quality benchmarks applicable to T4 PD Services. Community of Communities, and Enabling Environments.

4.2.2   Both programmes offer a peer review system which is coordinated by the College Centre for Quality Improvement (RCPsych). All T4 PD services should participate in one or other of these quality improvement programmes.

4.2.3   A PD network will be established within the footprint of each NHS England Area Team, to enable development of shared policies and protocols, with representation from service providers, clinicians, service users and commissioners. The provider will be actively involved in, and if required lead on, the pan regional network.

5. Applicable quality requirements and CQUIN goals

5.1   Applicable quality requirements (See Schedule 4 Parts A-D)

5.2   Applicable CQUIN goals (See Schedule 4 Part E)

The reference numbers for quality requirements and the CQUIN goals which apply to the service should be listed here. This allows clarity about the requirements relating to specific services.

Please note any contractual levers relating to quality, KPIs, CQUINs will need to be included in the relevant schedules of the contracts.

6. Location of Provider Premises

The Provider's Premises are located at:

ONLY LIST PROVIDERS IF THERE HAS BEEN A FORMAL DESIGNATION PROCESS.

7. Individual Service User Placement