



Ministry of
JUSTICE



**FORENSIC PERSONALITY DISORDER
MEDIUM SECURE AND COMMUNITY PILOT SERVICES
PLANNING & DELIVERY GUIDE
(Part of the DSPD Programme)**

DSPD Programme

Department of Health
Ministry of Justice

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Summary

This Planning & Delivery Guide covers the delivery of new pilot NHS forensic personality disorder services. These are based in medium security, community and hostel provision. The service users will be adult men with a personality disorder that is demonstrably linked to a high risk of offending. The risk will be such that it is likely to cause serious harm to others. These services will provide 75 medium secure and hostel places, with specialist community teams in support.

The pilot services are operating within the ambit of current mental health and criminal justice legislation. It is, however, an evolving picture. The Criminal Justice Act 2003 introduced new indeterminate sentences for dangerous offenders whose eligibility for release will be dependent on the level of risk they pose in terms of sexual and/or violent reoffending. Reforms of mental health legislation are also planned. We will keep under review how the treatment and management of personality disordered offenders can be supported by changes in the law.

Entry to the services will be based on structured clinical assessments using an agreed set of psychiatric and psychological tools. Individualised treatment will be planned and delivered and will be designed to reduce the risk of further serious offending, address personality disorder and improve social functioning. Patients will be actively encouraged to share in treatment planning and take ownership of treatment goals.

The programme will be subject to external evaluation and reports published. The contract for this has been awarded to the Institute of Psychiatry led by Dr Paul Moran.

Accountability for the programme rests with the interdepartmental DSPD Programme Board. This has overall responsibility for development and strategic management of DSPD services. The Mental Health Trusts hosting the pilot units are accountable for the services delivered within the framework of their existing statutory and other responsibilities, and this guide.

This guide will be reviewed as required.

**DANGEROUS AND SEVERE PERSONALITY DISORDER (DSPD)
MEDIUM SECURE AND COMMUNITY PILOTS SERVICES
PLANNING & DELIVERY GUIDE**

1. Introduction	5
2. Forensic Personality Disorder Pilots – Service Principles	5
2.1 Medium Secure and Community Services	5
2.2 Other DSPD Pilot Services	6
2.3 Planned Provision	7
3. Legislative Context	8
3.1 Mental Health Legislation	8
3.2 The Criminal Justice Act	8
4. Admission Criteria	8
4.1 Age Threshold	8
4.2 Women	8
4.3 Learning Disability	8
4.4 Admission to the Forensic Medium Secure Personality Disorder Pilot Services	9
4.5 Admission to Community Services	9
4.6 Admission to Hostels/Supported Housing Projects	9
5. Diversity Issues	10
6. Access to Services and Service Delivery	10
6.1 General Principles	10
6.2 Referral	11
6.3 Assessment	12
6.4 Risk Assessment Tools	12
6.5 Entry Requirements	13
6.6 Catchment Areas	13
6.7 Non – Admissions	14
6.8 Consent	14
6.9 Treatment and Interventions	15
6.10 Length of Stay	15
6.11 Secure Working Environments	16
6.12 Continuity of Care	17
6.13 Relationship with Other Forensic Services	17
6.14 Relationship with Criminal Justice and MAPPA	17
6.15 User Involvement and Advocacy	18
6.16 Evaluation	18
6.17 The Common Data Set	18
7. Service Management	19
7.1 Finance & Business Planning	19

7.2 Annual Reports	20
7.3 Training, Learning & Development	20
7.4 Human Resources	20
7.5 Construction	21
7.6 Communications	21
7.7 Complaints Procedure	21
7.8 Allowances & Entitlements	21
7.9 Governance & Accountability	21
7.10 Role of Audit & Inspection	22
7.11 Clinical Governance	22
7.12 Relationship with Mental Health In-Reach (Prisons)	22
7.13 Links with Probation & Wider PD Services	23
7.14 Commissioning Arrangements	23
7.15 Oversight Arrangements	23
Appendix A: Forensic PD Borough Catchment Areas for Pilot Projects	24
Appendix B: Glossary of Terms	25
Appendix C: The Assessment Tools	26
Appendix D: Business Plans	27
Appendix E: Annual Reports	29

1. Introduction

This document sets out advice about the planning and delivery of forensic personality disorder medium secure and community pilot services (hostels and specialist community teams) within the NHS. It describes those common elements to be delivered so that the pilots as a whole are coherent, in line with national policies and priorities, and achieve national objectives. The document, therefore, provides the background against which these pilot services are being funded, commissioned, performance assessed and evaluated. This guide also provides a framework for the provision of pilot systems for treatment, management and pathways in the health and criminal justice systems. This document will effectively be the specification for services alongside the Service Level Agreement (SLA) which will cover activity reporting and financial agreement for each service.

Pilot Trusts have discretion over the means of delivering services, within the framework set out in this document, and the clinical, management and organisational rules and procedures of the Trust in which they are located.

2. Forensic Personality Disorder Pilots – Service Principles

These pilot services are being developed under the umbrella of the joint Health Partnership DSPD Programme between the Ministry of Justice and The Department of Health. The Department of Health is taking the lead on developing the PD pilot services below high security, following the publication of the NIMHE document 'Personality Disorder, No Longer a Diagnosis of Exclusion'.

The overall purpose of the DSPD programme is to support the development and delivery of new services in order that people who present a high risk of committing serious violent or sexual offences as a result of a severe personality disorder can be managed and treated through the appropriate pathway of care.

2.1 Medium Secure and Community Services

The medium secure and community pilot services will cover host Trust agreed catchment areas and, in total, will provide 75 medium secure and hostel beds for men only, with specialist community teams in support and some additional activity is the result of developments during the pilot phase. However, it is intended that other new services delivering to this patient population will also work under the auspices of this document. To date, the following organisations have agreed to do so:

- St. Nicholas' Hospital, Northumberland, Tyne and Wear NHS Trust
- Bethlem Royal Hospital, South London and Maudsley NHS Foundation Trust
- The John Howard Centre, East London and City MH NHS Trust
- The Bracton Centre, Oxleas NHS Foundation Trust
- Merseyside Probation Service (NOMS) and Mersey Care MH NHS Trust

The underpinning philosophy of the DSPD Programme is that public protection will best be served by addressing the mental health needs of a previously neglected group. This guidance will be used if in the future funding becomes available and evaluation indicates effectiveness, to develop further pilot medium secure and/or community forensic services.

2.2 Other DSPD Pilot Services

High Secure Services: developed and being piloted at Rampton Hospital (70 beds), Broadmoor Hospital (70 beds), Whitemoor Prison (77 places), (reduced from the previous 84 places due to recruitment issues) and Frankland Prison (86 places). This will deliver the Government commitment to provide just under 300 high secure places for men.

The target outcomes of this part of the programme are:

- How to identify, assess and treat those who are dangerous and severely personality disordered
- The nature and challenges of treatments and service delivery involving multi-disciplinary teams working across agencies
- The extent to which treatment might reduce (or manage better) the risks of re-offending and how best to move on those offenders who have benefited from the programme, as well as those who have not
- To strengthen the clinical, service delivery and policy evidence base in this area, informing the options for future services, and the costs and benefits

Separate guidance has been developed for the planning and delivery of these services.

Pilot services for women: High secure services are being developed through a partnership between the Prison Service and the Tees, Esk and Wear Valleys NHS Trust (the Primrose Project) providing an outreach service for women prisoners. This is based at HMP Low Newton. Once again, separate guidance has been developed for the planning and delivery of this service.

Research & development programme: Whilst the DSPD Programme is providing a new service it is also a pilot with research as a core part of its remit. Plans are being implemented for independent evaluations. The research programme can be broadly divided into the following areas:

- The relationship between personality disorders and serious offending. Risk and personality disorders are complex areas and improved understanding of the relationship between the two will be important to the effective treatment and management of this group
- The aetiology and development of personality disorder. This work is about the potential to prevent the development of severe personality disorder and ameliorate the behaviours associated with it. Greater understanding may offer the potential to improve approaches to treatment
- The validity and reliability of the assessment and treatment models used in the programme. It is essential that the instruments that are used to identify this group are both valid and reliable across different age groups, gender and

ethnicity. Treatment for this group represents a central aim of the programme. Due to their challenging nature they have often been neglected or excluded from other services.

Research, updates and other relevant documents are published on the DSPD Programme website www.dspdprogramme.gov.uk.

2.3 Planned Provision

Five pilot services

Northumberland, Tyne and Wear NHS Trust

16 permanent beds from Feb 2006

Community team and access to hostel beds – from November 2003

South London and Maudsley Mental Health NHS Trust

16 permanent beds from autumn 2006

Community team and specialist PD hostel from Oct 2004

East London and the City Mental Health NHS Trust

20 permanent in patient beds from December 2005

Community team and specialist PD supported housing from Dec 2004

Oxleas Mental Health NHS Trust

6 Specialist PD hostel and outreach team from June 2004

Merseyside Probation Service (NOMS) and Mersey Care Mental Health NHS Trust

30 place Community Risk Assessment and Case Management Service (CRACMS)

These new services will help to develop the expertise in the assessment, treatment and management of personality disordered offenders within the NHS. To do this they will need to develop a working relationship with a wide range of other services, for example, local forensic and general mental health services, the probation service, the prison service, the high secure DSPD pilot units and voluntary sector service providers.

The medium secure and community PD pilots will deliver the Government commitment in the NHS Plan to provide 75 medium secure and specialist hostel places for people with personality disorder and some additional activity is the result of developments during the pilot phase. The outcomes for this part of the wider DSPD Programme are:

- To model the provision of new treatment services that improve psychological health outcomes and reduce risk
- Enhance public protection
- Improve the evidence base about what works in the treatment and management of individuals with personality disorder who are at high risk to others
- Develop an appropriately skilled workforce
- Provide better pathways between services

3. Legislative Context

3.1 Mental Health Legislation

These services have been developed to operate in the context of current mental health legislation.

3.2 The Criminal Justice Act

The Criminal Justice Act 2003 includes new sentencing provisions that take specific account of assessment of risk in determining time to be served under sentence. These are likely to have a significant impact upon the operation of all forensic personality disorder services. The new indeterminate sentences will put the work of personality disorder units into sharper focus, since a prisoner's eligibility for release will be explicitly and formally linked to evidencing a demonstrable reduction in level of risk. It is anticipated that forensic personality disorder services will have a developing role as their expertise grows in providing risk assessments to help inform decisions about the management of dangerous offenders and the risks they might pose either in custody or the community if released.

4. Admission Criteria

4.1 Age Threshold

The age threshold for admission to medium secure and community pilot PD services is 18 years and over.

4.2 Women

The numbers of women who are likely to meet the current DSPD criteria are small, currently estimated as around 50. The women's prison DSPD pilot at Low Newton (Primrose Unit) is now developing services to meet the needs of this small but high profile group by offering 12 places. More appropriate pathways through medium and community services for the small number of women with personality disorder who are currently in the women's high secure at Rampton Hospital will also need to be developed.

In the high and medium secure NHS services and criminal justice system there is a significant population of personality disordered women whose behaviour is challenging and have complex psychological needs. With the focus on public safety, these groups have not been a priority because they often present more risk to themselves rather than others. The national PD Programme, in collaboration with NOMS, will be seeking to develop initiatives to provide more effective interventions.

4.3 Learning Disability

These pilot services will not offer a service for those with a learning disability as defined as a full-scale IQ score below 70 measured using the Weschsler Adult Intelligence Scale. Patients scoring 70 – 80 will be considered on an individual basis to assess their capacity to engage with the treatment and interventions provided. However, there are different schools of thought about IQ and, therefore, any fixed rules are difficult to define at this time. As a part of the assessment process, issues relating to the patients' cognitive abilities will be considered and it is likely that there will be potential patients for

whom these services are unsuitable. The Directorate of Health and Offender Partnerships will be considering the service provision needs of patients with learning disabilities with personality disorder as part of the post Stocktake Review work programme.

4.4 Admission to the Forensic Medium Secure Personality Disorder Pilot Services

This section focuses on the medium secure in-patient pilots. The admission criteria for these services are that:

- The patient has a diagnosis of a personality disorder which would meet the criteria for detention under mental health legislation. Where there is a dual diagnosis of mental illness, the mental illness should be stable and unlikely to interfere with treatment focusing on personality disorder
- The patient presents a serious physical or psychological risk to others or potential risk of a degree that requires admission to a medium secure service, and
- There is a link between the personality disorder and high risk that can be clinically justified
- The treatment needs of the patient are best met in a secure NHS setting

4.5 Admission to Community Services

Admission to the Community service will require:

- A diagnosis of a personality disorder
- A history of serious risk to others associated with that disorder
- The nature of the risk can be better managed through the intervention of these services

Patients accepted by these services will require (because of continuing personality difficulties and risk) the expertise of the specialist multi-disciplinary team. The local situation will dictate whether such patients are subject to co-working arrangements with non-specialist PD services, and which service will take a leading role. In some circumstances, therefore, the service will be contributing to the risk management work of other agencies.

4.6 Admission to Hostels /Supported Housing Projects

Admission to a specialist hostel supported housing project will require:

- a primary diagnosis of a personality disorder
- a history of serious offending against the person, and / or a significant potential for future harm to others
- that all other local provision (whether hospital based or community) is agreed clinically not to meet their needs
- that the hostel / supported housing project is agreed clinically to be an appropriate setting to provide a service in line with the individuals treatment/management plan

5. Diversity Issues

The medium secure and community pilot services must ensure that (prioritised) access to PD services is given to those who meet the criteria. However, no assumptions as to suitability should be made on the basis of ethnicity, race, disability or previous clinical pathway.

Treatment plans should take account of patient's ethnicity and cultural needs. Information about ethnicity will be part of the common data set used for evaluation, and the pilots should be actively monitoring the ethnic mix of those referred, accepted or rejected, to ensure that the criteria are being applied objectively.

Staff working within pilot units should receive training in cultural awareness and sensitivity and in tackling incidences of racism. Units should have a written policy, integrated with that of the host Trust, dealing with racist abuse. Adherence to the policy should be regularly monitored. This may be the same as an existing Trust policy.

Where appropriate, active steps should be taken to promote the recruitment and retention of suitably qualified black and minority ethnic staff. The aim is to achieve workforces within units that are representative of the ethnic diversity in the community.

In community mental health services black and minority ethnic (BME) people are less likely to receive a diagnosis of personality disorder. The research evidence suggests they are more likely than white people to receive a diagnosis of schizophrenia, more likely to receive medication and less likely to be offered psychological interventions.

Until the pilot services are up to capacity and data analysis of the referral, admission and discharges is available no specific actions on issues of diversity will be enacted. We will continue to monitor the situation and be alert to any indications of adverse impact.

With each pilot it is expected that all appropriate actions to ensure implementation on delivering race equality are put in place.

6. Access to Services and Service Delivery

6.1 General Principles

The medium secure and community pilot services are only expected to provide services in the Trust catchment area that they cover. In London there is now an agreement for Medium Secure P.D. access to cover Greater London SHA catchment. The current planned places represent a very scarce and limited resource and, consequently, it is unlikely that all need in their catchment area will be met. For this reason, referrals are unlikely be accepted from outside the catchment area although modelling patient pathways remains an important objective of the DSPD programme and consideration could be given on an individual case need. This would only be on the basis of a negotiated agreement and where it correlates with available capacity.

Depending on the progress with developments and evaluation outcomes this principle will be reviewed. Services would consider taking patients from the catchment area of another pilot where it is good practice to do so. This might be where another service is

providing a more appropriate treatment regime for the patient, to provide support in relation to patient mix and manageability, to better manage victim issues, and so on.

6.2 Referral

The medium secure and community PD services will accept and consider referrals from:

- Prisons
- Probation services
- Courts
- Other NHS services
- Independent psychiatric hospitals
- MAPPP's (Multi Agency Public Protection Panels)

The services with inpatient beds, community teams and hostels will be able to move patients between these parts of the service as appropriate.

Where it is clinically appropriate, assessment and admission from high secure Prison DSPD Pilots as well as high secure PD Services will be made if the patient falls within the agreed catchment area. Services should be aware of all potential patients detained in high security and, where appropriate, contribute to their care planning.

The medium secure and community PD pilot services will need to develop clear access routes for new referrals, so that timely decisions may be made as to whether a patient is appropriate for assessment by either the secure unit or the community service.

There is likely to be considerable demand for access to these services. It is expected that each service will manage the referral process and establish a system for managing waiting lists and prioritising patients. Priority will be determined by clinical need and degree and imminence of risk to the public, the latter often depending on when and if a prisoner is due to be released. Good practice dictates that prisoners serving determinate sentences likely to meet the criteria should be identified as early as possible in the course of their prison term, and that their assessment and treatment plans are, so far as possible, developed in consultation between the prison and the receiving service. It is expected that referrals from prison will be received no later than 2 months in advance of the prisoners expected date of release (EDR). The DSPD Programme central team will work with NOMS, the Prison and the Probation Services to develop arrangements for earlier identification and referral of potential patients.

The limiting factor for the community teams will be the agreed case load ceiling for each team worker. Whilst there are national guidelines, this will be informed by local practice and style of case management.

Referrals of serving prisoners to hospital can be made direct by the referring establishment. It is not always easy for a referring establishment to decide whether a prisoner should be referred initially to a high security DSPD pilot unit, a high security hospital (Ashworth Hospital, Rampton Hospital) PD service, or one of the new medium secure and community pilot services. In those cases where there is a degree of doubt as to the most appropriate service, clinical judgement should be used to identify the service that best meets the prisoner's clinical and risk needs. This should be undertaken

by the referring and receiving establishment in consultation with each other. For those referred to the medium secure and community pilot PD service, there should be sufficient case information to indicate why the referral has been made. It would generally be helpful to discuss the issues with the service concerned where there is any doubt. In such cases, suitability of the referral would be validated by the receiving PD pilot service as a first stage of the assessment process. With Prison Service referrals it is expected that the prisoner's catchment Medium Secure Unit will act as initial gateway for referral to the PD MSU Service.

The casework for the transfer of prisoners or restricted patients to hospital will be managed by the Ministry of Justice Mental Health Unit (MHU), as part of its role in administering the Secretary of State's responsibilities under the Mental Health Act.

6.3 Assessment

Individuals referred to medium secure and community pilot PD services will be assessed to determine if they meet the agreed criteria. Each service may have different approaches (subject to the common core elements described below) to the process. It may be advantageous for as much of the initial assessment as is possible to be carried out before patients are admitted to the service.

Assessment will have several functions:

- to establish whether an individual referred to the service meets the admission criteria for personality disorder, risk and there being a link between the two
- to identify any other mental health, criminogenic and social functioning needs
- to provide a formulation on which to base treatment needs and to inform the development of a care plan
- to facilitate the measurement of change, for example, whether there has been a reduction in risk following treatment i.e. establishment of a baseline for evaluation
- to inform a common dataset
- to inform future/alternative services by providing an objective assessment and to contribute to a forward care pathway plan

The judgement about the above will, so far as possible and within the present state of knowledge and practice, be objective and evidence based. In this respect both static and dynamic tools will be used to help inform a structured clinical judgement.

Assessments will be carried out using (as a mandatory minimum) the following set of tools. The DSPD Central Programme team will work with the clinical teams to establish appropriate training for the delivery of the required tools:

6.4 Risk Assessment Tools

Violence

- VRS
- HCR-20

Sexual offending (only for sex offenders)

- Risk matrix 2000
- Static 99

- SARN (for MSU inpatients anticipated to stay 3 months+)
- STABLE 2000 (for outpatients and those in hostels)

Personality Disorder

- PCL-(R)
- PCL:SV
- IPDE

Mental Illness

- SCID-1

Social functioning

- The units are expected to assess social functioning, however, there is not a prescribed tool or process for completing this

6.5 Entry Requirements

Each of the medium secure and community pilot services will over time develop their practice, expertise and confidence in managing offenders with personality disorder, and this will inform the admission criteria.

Other tools may be used, at local discretion, to augment the core assessment tools. Where this is done the services should explain the rationale behind their use; how they help improve the assessment and/or treatment processes, and how their use will be evaluated.

It is expected that a full social and criminological history will form the basis of all assessments. It is recognised that these tools, either individually or collectively, will not always be capable of discriminating between those presenting different forms and levels of risk. There may be circumstances where a clinical override will need to be exercised, where it can be shown that an individual would be excluded by reliance upon the tools alone, but for whom there is other compelling clinical evidence that points to them posing a high risk. The use of an over-ride should be an exceptional measure and clear reasons for its use recorded in each case.

The process of assessment must as far as possible be transparent. There is a need to ensure that the process of selection for these services does not operate in such a way that the most difficult or challenging candidates for treatment are excluded from the system.

6.6 Catchment Areas

The catchment area for each Trust is detailed in Appendix A. This arrangement will be subject to review as services become established and patient usage and demand is monitored. It is intended to establish model pathways to ensure that patients are appropriately placed at the right time in line with their clinical and security needs.

6.7 Non-Admissions

For prisoners/patients who are assessed by these pilot services, but are not accepted, a report will be provided. This should provide:

- Full details of the assessment and why the individual was not accepted by the service

- Where appropriate, advice on referring to a more appropriate service
- Recommendations for the future management and care of the individual
- (if appropriate) Recommendations on referral back to the pilot services at a later date

6.8 Consent

Pilot services should ensure as far as practicably possible that individuals admitted are made fully aware of what assessment and in due course (if accepted) what treatment will involve, and what their expectations may be in terms of participation in the programme. Patients / prisoners should clearly understand why they have been referred and what the goals of their particular treatment plans are.

In order to treat patients with personality disorder in a secure hospital setting there will need to be clear potential that the patient will engage in the assessment process, and develop the necessary therapeutic alliance that will allow psychological treatments to be effective. However, it is also clear that for many patients there will be considerable ambivalence and the early stages of any intervention will acknowledge that work to establish an alliance and a positive commitment to treatment is a key aim of clinical and managerial tasks. All patients admitted to the in-patient services will be detained under Mental Health legislation.

Part of the initial assessment will be to review whether or not the patient will be able to benefit from the assessment and treatment opportunities available. Sometimes the situation is clear, at other times it may be necessary to provide an initial in-patient assessment bed so that the patient's willingness to co-operate can be determined. A key part of this process will be the motivation and engagement of the patient. Resistance to treatment will not necessarily be a barrier to admission for treatment.

This is a different framework from the proposals set out in the High Secure Planning & Delivery Guide, where it is accepted that some individuals will be unwilling participants, and where units are not generally required to seek formal consent before admission. For the community PD pilot services (specialist community teams and hostels) consent is an essential element to the provision of these services. An individual cannot be forced to live in a hostel, and it is difficult to provide community support for an unwilling recipient under the current Mental Health Act legislation. This situation may change with the new community treatment proposals in the Mental Health Act 2007.

Consent to use of data

The normal processes for the handling of patient information and data apply to these pilot services. This includes Caldicott guidelines and data protection legislation. Similarly, the same NHS rules should apply to research, with ethics approval and patient consent.

There should also be in place a policy for copying letters and/or other relevant documents to patients.

6.9 Treatment and Interventions

Development of treatment and intervention services is the responsibility of individual services and will be identified in the SLA. The treatments or interventions offered or being developed will aim to:

- Address and reduce the risk of re-offending
- Address mental health needs
- Improve social functioning

Each pilot service will prepare, and review annually, a clinical service plan that sets out:

- The treatments or range of interventions offered
- The evidence on which they are based
- Any local evaluation plans to assess their effectiveness

Certain principles and goals are expected to be common to intervention programmes in all pilot services. In particular, services will need:

- To be based on models, grounded in evidence, susceptible to rigorous validation and external evaluation
- To provide individualised plans that are tailored and flexible, with regular progress reviews
- To involve patients in their plan, gaining ownership of treatment outcomes, and having transparency of process
- To address offending behaviour through the reduction of risk, by targeting criminogenic factors and meeting mental health needs

6.10 Length of Stay

It is common practice within medium secure NHS services for in-patients stay to be no more than two years. For the PD pilot in-patient services, it is not unreasonable for the length of in-patient stay to be similar. However, these are new services, and the management of personality disorder and risk is probably a longer-term task than for those with a mental illness. The decision on length of stay will focus on evidence of a capacity to engage with the treatment programme and the impact on change and reduction of risk.

Patients will present the services with differing treatment needs, and with different attitudes towards, and capacity for, treatment. It is inevitable that length of stay, and the amount of progress that can be expected over any given period, will vary between individuals. Nevertheless, one would not expect many patients to remain an in-patient in these services for longer than three years.

This means that individual treatment plans should be goal-focused and time-constrained. Patients who remain in hospital beyond two years should be subject to an annual review, which should consider:

- The progress made by the individual to date
- The reasons why move on at two years is not appropriate
- Realistic goals for the remaining period of treatment
- A plan for moving on
- A review of the level of risk

Each community service will need to develop its own clinical practice. The requirements of this guidance, the relationship with local services, the wider health and social care environment, and size of catchment area will inform this.

The need for longer term (3+ years) treatment arrangements will be considered by clinical and commissioning teams as an aspect of future planning. There may well be some patients who need long term follow up by a specialist team, because of the nature of the personality disorder and the specific risks. For the majority who do not require long term specialist care, agreement will need to be reached with local services how patients are handed over. For those services that apply a joint case working strategy, this will be an easier task. In order to prevent disagreement at handover stage each community service must have clear policies and jointly agreed protocols in place with relevant services and agencies.

The specialist hostels will need to have in place policies that will guide staff in finding onward accommodation when it becomes necessary for a resident to move either in a planned or emergency situation. Clearly this will require agreements to be in place with appropriate agencies.

6.11 Secure Working Environments

Patients with personality disorder can be challenging, confrontational and manipulative in their behaviour. They can be expected to test boundaries and to identify and exploit any weaknesses that may exist in the operational system, or in working relationships in the pilot services. This can pose a significant risk to the health and safety of all staff working in these services, and to the security and integrity of the services themselves.

Security and safety within the pilot medium secure and community PD services should be maintained at levels commensurate with the patient population and assessed risk. The provision of appropriate care and clinical treatment must be balanced against the safety of the public, the staff and of the other patients.

The in-patient, hostel, and community pilot services should regularly review protocols to confirm that they are sufficiently robust to meet the particular challenges of offenders with personality disorder. In particular, they should ensure that:

- Operational policies and procedures are open, clear and regularly reviewed
- Systems are in place to record and analyse information on all incidents and “near-misses”
- All staff have access to regular supervision and staff support services, including those contracted out (e.g. hostels)
- Staff absences (especially levels of sick leave) and patterns of recruitment and retention are actively managed and monitored
- Services operate on an integrated, multi-disciplinary basis
- A management culture of trust and openness is developed – with an emphasis on positive exploration of error and learning from mistakes

6.12 Continuity of Care

The DSPD Programme as a whole is promoting the creation of suitable facilities and the means of progression through the system for offenders with personality disorder. For the high secure, medium secure and community forensic pilots this will include both

those who move on as part of a planned progression, and those who leave for other reasons (e.g. respite, or no longer able to engage effectively with treatment).

To support this process, the pilot units will need to provide statistical and strategic planning information relating to their population on the:

- Profile of prisoners/patients who will be leaving the units
- Clinical and other needs
- Recommendations as to future management and care
- Flow information mapping out the numbers leaving the units

The DSPD Programme will also support the development of aftercare services within the Prison Service for those who move from DSPD units to a lower level of security or return to high secure settings. It will work with Probation Service to develop appropriate community services for those ultimately released from prison.

6.13 Relationship with Other Forensic Services

Each of the pilot services is being developed in association with already existing forensic mental health services. This will allow the “forensic campus” to take advantage of shared policies and procedures, staff education and development systems, and to link in with training providers. There will clearly be many other benefits to the relationships with secure forensic services and other mental services within the host Trust.

6.14 Relationship with Criminal Justice System and MAPPA

The pilot services will need to develop a working relationship with the prison estate, and specifically where there are prisoners within their catchment area. Referrals may come from any part of the prison estate if the person lives in the catchment area. This will be a common referral route and it will be necessary for the pilot services to provide information to referrers in the criminal justice system so there is a clear understanding of what the services may offer and what it does not.

This includes the local probation services and the local MAPPA. There will need to be agreement with local MAPPA as to how individuals thought to be suffering from personality disorder are referred to the relevant pilot services and how these services will be represented and by what level of practitioner.

There will need to be clear agreement about the role of these pilot services in the local MAPPA process as many individuals identified as requiring health assessment or involvement will not have a personality disorder.

6.15 User Involvement and Advocacy

New services are expected to develop a proactive approach to the complex issue of patient involvement in forensic care. A key starting point is the development of treatment planning that engages with the patient and clearly determines the boundaries between choice and requirement. Patient engagement and development of a therapeutic alliance will develop respectful and realistic expectations in planning and delivery of care. All pilot services should have processes in place to ensure patients have appropriate access to advocacy services, and that patients have the opportunity to

be involved in the operation, and planning, of services. Carers and/or the nominated person should also be involved in the planning of services.

6.16 Evaluation

The whole DSPD programme represents an innovative approach in an area with considerable uncertainties, especially in the design and delivery of effective treatment programmes. External evaluation and validation of treatment delivery, and of the outcomes achieved, will be a key component of the programme. External evaluation will be commissioned centrally. It will be informed by a common data set and by the advice of an independent Expert Group established to provide guidance in relation to the research and evaluation aspects of the DSPD programme.

Beyond the process of external evaluation, it is expected that pilot services will develop processes to evaluate and validate their own facilities, treatments or interventions.

6.17 The Common Data Set

Evaluation will be informed by data collected via the common data set, which will be common to the high secure, medium secure community and pilot hostel services. The common dataset will be collected by all units. These data will facilitate the evaluation of the units by providing a common format describing all those entering treatment at the unit. It is the responsibility of the lead clinician to ensure that these data are recorded and provided to the common data set project in the approved format. The data set comprises:

Demographic factors

- Date of Birth
- Ethnicity
- Legal status, lifer/determinate sentence prisoner, length of sentence
- Employment, education - when education left, highest levels of achievement
- Date, reason and source of referral
- Date of arrival to and departure from the unit
- Date of departure, and reason

Criminal history

- Total convictions, index offence, PNCID number, institutional misconduct
- Adult - age, number and type of offences (charges, convictions, arrests etc) (major violence, minor violence, sexual violence)
- Juvenile/youth – offending history

Risk factors

- Static tools (Static 99, Risk Matrix 2000)
- Dynamic tools (VRS, HCR-20, SARN)
- Nature of risk – general, sexual, other

Mental disorder

- Axis I - Mood, Psychotic, Organic, Substance misuse (drug and alcohol), IQ
- Axis II - personality disorder(s) - PCL-(R) / PCL-(R) SV
- Number of previous admissions to hospital

Treatment

- What treatments have been delivered over what duration

The common data set will continue to be reviewed in light of experience.

7. Service Management

7.1 Finance & Business Planning

The finance and business planning processes for the pilot services should comply with the business planning requirements of the Trust in which they are based, and report as appropriate to the relevant Specialist Commissioning PCT and Strategic Health Authority.

The DSPD programme will agree with local commissioners the financial planning and performance management arrangements for the pilot services, which will be incorporated into a service level agreement. SLA meetings between each Trust and the commissioners will be held on a quarterly basis. Reports on finance and development targets will be received by commissioners no less than 2 weeks prior to the agreed dates.

The DSPD programme will expect an annual business plan, which details

- the full cost of delivering the pilot services for the year
- how the processes and mechanisms for local delivery of the pilot services, as set out in this document, will be implemented
- the key risks to delivery of the programme, and how they will be managed
- Other requirements as requested by the Centre (a suggested template can be found at Annex D)

As part of the performance management arrangements to be agreed with commissioners, pilot services will provide regular reports on expenditure against budget, explain any variances and project the year-end position.

Under-spends should not be diverted to areas outside the service level agreements without prior agreement from the commissioners and DSPD programme manager. Any budget tensions or concerns likely to impact upon delivery of the programme should also be reported at the earliest opportunity to the commissioners and the DSPD programme manager for the medium secure and community pilot PD services.

7.2 Annual Reports

Each Unit will be expected to produce an annual report which details progress made against agreed delivery targets and milestones for the preceding financial year. The report should contain narrative on:

- The key challenges faced by the units during the course of the year, and the steps taken to address them
- Successes – what has gone well during the year
- Areas identified requiring further development / improvement
- Lessons learned for the unit and/or the programme as a whole
- Other requirements set by the central team (a guide template can be found at Annex E)

7.3 Training, Learning & Development

Each unit will put in place policies and practices that enable all staff to develop and maintain the necessary levels of competency and experience to work safely and effectively with patients. Where relevant, as a minimum, professional staff need to carry out continuing professional development in order to maintain professional registration.

The Personality Disorder Capabilities Framework provides the reference point for identifying the training and development needs of staff at all levels and should be used as the basis of Trust plans. All pilot sites are expected to have:

- Training needs analysis to have been completed
- Induction programmes in place
- Establish a set of measurable and attainable core staff competencies

The DSPD Programme team will facilitate regular “Clinical Forums”. Which will provide opportunities for networking and sharing of information and good practice between all the pilot sites, and other parts of the mental health and criminal justice services.

7.4 Human Resources

It is recognised that staffing the forensic personality disorder medium secure and community pilot services will present significant challenges. Trusts will be required to recruit and retain adequate numbers of suitably skilled staff, drawing upon limited resources and a labour market that has insufficient qualified staff.

- HR issues will be managed by the Trusts in which the pilots are developed, and in line with arrangements they have in place regarding any contracted out services
- The DSPD Programme will address any critical HR problems that would benefit from a national, rather than a local, approach

7.5 Construction

Where new or refurbished accommodation is required for pilot services, the Trusts will be responsible for the development, design and delivery of such accommodation – subject to funding approval. Progress on construction will be managed and monitored via local Steering Groups. Trusts will bring any issues or concerns relating to construction (e.g. timetable slippage or budget tensions) to the attention of the central project support team via the DSPD Programme construction advisor at the earliest possible opportunity.

7.6 Communications

Pilot services will contribute to delivery of a commonly agreed communications plan for use by all sites. Pilot sites will also develop and implement their own local communication strategies and manage the local issues appropriately.

The DSPD Programme central team will ensure that the website is kept up to date and reflects the input provided by the pilot sites.

Due to their nature, media interest will inevitably be focused upon the services and the programme as a whole. Proactive engagements with appropriate media sources will be important so that key messages on personality disorder are successfully communicated. The DSPD Programme Central Team should be advised of any approaches by the media.

7.7 Complaints Procedures

The process by which patients can make a complaint or register a request should be open and transparent. Patients should be given clear information on who to contact and the procedures involved.

As a general principle, services will be expected to follow a procedure of local investigation followed (where the issue cannot be resolved to the complainants satisfaction) by an external review through the NHS complaints procedure.

In hostels, where a service is provided by a third party, complaints processes should be clearly defined in the service level agreement and operational policies.

7.8 Allowances & Entitlements

The level of and scope for earnings, allowances or entitlements awarded to patients in the PD services should remain broadly in line with (and be comparable to) the standard arrangements for the Trust's other forensic services.

7.9 Governance & Accountability

The medium secure and community PD pilot services are organised as follows:

- The DSPD Programme Board (Health & Offender Partnerships) has overall responsibility for development and strategic management of services and will retain a clinical adviser for the programme
- The local Mental Health Trusts via their Chief Executives and Boards are accountable for the services delivered in their respective organisations, within the framework set out in this guide
- Performance management above that level will be via the specialist commissioners on behalf of PCTs and Strategic Health Authorities
- The pilot services will provide reports to the Project Management Group and DSPD Programme Board on a range of issues. The content of these reports will be guided by this document, the SLA or as otherwise agreed
- The SLA for each of the Medium Secure & Community pilots will be held by the relevant Specialised Commissioner and the oversight of delivery and investment integrity as agreed with SHAs maintained by the DSPD/PD Central Team

7.10 Role of Audit and Inspection Bodies

Inspection of the work of the pilot services will fall to the NHS Healthcare Commission. These inspections will generally encompass all activity within the host NHS Trust and will not be limited in scope to personality disorder services.

Teams conducting inspections should take account of the advice and guidance set out in this document, so that they are aware of PD policy and service expectations.

Investigation of any serious incidents occurring within the pilot sites – suicides, other deaths or serious injury etc – will be carried out in accordance with the current policies and procedures of the parent organisation. The National Patient Safety Agency will play a similar role for these pilot services as in the host Trust. The DSPD Programme Central Team should be advised at the instigation of any such investigations.

7.11 Clinical Governance

Clinical governance for delivery of assessment and treatment services within the pilot services rests within the host Trust. Arrangements to improve the co-ordination of clinical leadership across the DSPD development programme will be considered as part of the DSPD Stocktake Review in mid to late 2007.

7.12 Relationship with Mental Health In-Reach (Prisons)

The Prison Mental Health In-reach Collaborative has been developed in partnership with the National Institute for Mental Health in England (NIMHE) and the Regional Development Centres. The aim of the collaborative is to improve the mental health care provided to prisoners who need it, and to help in providing the correct numbers of appropriately trained and skilled staff. In particular, it has the following objectives:

- To establish a process for the implementation of the Effective Care Co-ordination (ECC) Care Programme Approach (CPA) in prisons
- To implement the mental health component of the Health Promotion Strategy in prisons
- To improve transfers between prison and NHS units
- To identify training requirements from the collaborative process and ensure they are met

The pilot sites should work with key prisons and their in-reach teams to ensure the continuity of care and treatment of prisoners who have moved on or out of units, or who have been returned to their place of origin following initial assessment. Where possible, the care plans of those returning to mainstream prison health services should be discussed with the receiving in-reach team.

7.13 Links with Probation and Wider PD services

It is important that the DSPD programme operates in a way which is congruent with the wider Personality Disorder Strategy in health, and forms effective linkages with arrangements in place for the management and supervision of offenders in the community (e.g. the MAPPA and the Assertive Outreach mental health services facilitated through NIMHE). Pilot sites will be expected to:

- Support continuity of care through assessment of ongoing and long-term risk, and recommendations for future treatment

- Maintain effective links with aftercare providers in order to monitor and review the (longer-term) effectiveness of assessment and treatment services provided by the pilot services

7.14 Commissioning Arrangements

The DSPD programme will develop and maintain linkages with the relevant health commissioning bodies to ensure that

- There are clear, agreed lines of accountability and responsibility that take account of any transitional activity
- Funding streams for patients to be admitted to the pilot sites are clearly mapped
- Contribute to ongoing PD capacity planning through local catchment groups and NIMHE PD leads etc
- Pilot sites are adequately resourced to meet projected operational needs

Case management arrangements for patients in secure units will be the same as those for other secure patients. On receipt of a referral, the pilot site will contact their Specialist Commissioner and relevant secure case management. Responsibilities under case management will be equivalent to those for any other secure patient, and current processes will apply to all patients managed within the pilot services.

7.15 Oversight Arrangements

As a national policy programme still in a pilot phase an SLA with the relevant SHA provides the basis of the requirement to meet the objectives of this Planning & Delivery Guide and to continue to oversee the focus and effectiveness of the investment on behalf of the DSPD Board.

Arrangements to implement this oversight function through the National PD Programme Team will be put in place. This function will be in collaboration with Specialised Commissioners, SHAs and Regional PD leads.

Appendix A – Forensic PD Borough Catchment Areas for Pilot Projects

South London & Maudsley NHS Foundation Trust – Primary Catchment

- Lambeth
- Southwark

East London & The City Mental Health NHS Trust – Primary Catchment

- Barking & Dagenham
- Hackney
- Havering
- Newham
- The City of London
- Tower Hamlets
- Waltham Forest
- Redbridge

Access to these two London based services will extend to the Greater London SHA region when capacity and priority allow.

Oxleas NHS Foundation Trust

- Bexley
- Bromley
- Greenwich
- Lewisham

Northumberland, Tyne and Wear NHS Trust

- Newcastle & North Tyneside
- Northumberland
- South of Tyne & Wearside
- Co. Durham & Darlington
- Teesside
- N. Cumbria

Merseyside Probation Service (NOMS) and Mersey Care MH NHS Trust

- Cheshire
- Cumbria
- Lancashire
- Merseyside
- Greater Manchester

Appendix B – Glossary of Terms

CPA	Care Programme Approach
DSM-IV	Diagnostic & Statistical Manual IV
DSPD	Dangerous and Severe Personality Disorder
HCR-20	Historic – Clinical – Risk (assessment tool)
IPDE	International Personality Disorder Examination
MAPPA	Multi-Agency Public Protection Arrangements
MAPPPs	Multi-Agency Public Protection Panels
NIMHE	National Institute for Mental Health in England
NOG	National Oversight Group
PCL-(R)	Psychopathy Check List (revised)
PCL: SV	Psychopathy Check List – Screening Version
PCNID	Police National Computer Identification
PCT	Primary Care Trust
SARN	Structured Assessment of Risk and Need
SCID	Structured Clinical Interview for DSM-IV, mental illness
SMG	(DSPD) Service Management Group
SHA	Strategic Health Authority
VRS	Violence Risk Scale

Appendix C – The Assessment Tools

The table below is intended only to give a brief overview of the tools used in the forensic PD assessment process. It should not be used for definitive advice on the use or application of any of the tools. Readers requiring more detailed information should consult the appropriate technical specification.

[tool descriptions to be further developed]

Tool	Description	Comments
SARN (Structured Assessment of Risk and Need)	Dynamic tool for working with sex offenders.	For use in development of treatment plans and measuring change
STATIC 99	Actuarial tool for measuring risk in sex offenders	
HCR-20 (Historic – Clinical – Risk)	Risk assessment in violent offenders	20 fields combine static and dynamic factors – supports the development of risk management plans
VRS (Violence-Risk Scale)	Risk assessment in violent offenders	Strong dynamic element supports measurement of change and formulation of treatment plans
Risk Matrix 2000	Risk assessment tool that categories sexual and violent offenders from low to very high risk	
PCL-R and PCL:SV (Psychopathy Checklist)	Used to measure the presence and level of psychopathy in an individual	Tool also proven effective predictor of risk. Short (SV) version can also be used in non-forensic populations
IPDE (International Personality Disorder Examination)	Measures personality disorder using DSM-IV (Diagnostic & Statistical Manual of Mental Disorders) or ICD-10 (International Statistical Classification of Diseases and Related Health Problems) criteria	Use of this tool is a component part of the structured clinical diagnosis of personality disorder
SCID-1 (Structured Clinical Interview for DSM-IV-TR)	Semi-structured interview used to assist clinicians in the diagnosis of axis 1 mental illnesses	

Appendix D – Business Plans

Generic Business Plan Template

1. Introduction/Executive summary
2. Summary of 2008/09 performance:
 - A brief over-view of achievements, set-backs and on-going challenges.
3. Summary of objectives for 2008/09
 - What do you hope to achieve this year (expressed as clear and quantifiable outputs divided into the four quarters of the financial year) and where do you think the problems/challenges may be?
4. Costs overview
 - A high-level overview of where the costs will fall (again broken down quarterly).
5. Business plan assumptions
 - What assumptions have you made in your planning? (e.g. resources available, number of referrals, patient/prisoners in assessment/treatment etc, how will the deliverables grow during the period)?
6. Financial management strategy
 - How will you manage your finances? What value for money initiatives will you be launching this year?
7. Assessment and treatment strategy
 - What is this and what will it deliver during 2008/09?
 - This needs to be more than just a description of what your assessment and treatment processes are – we need to understand what the deliverables/outputs are, broken down by quarterly estimates (e.g. the number of patients/prisoners to be assessed or treated at the various phases of your treatment programmes).
8. Staff recruitment, retention and development strategy
 - Again, what is this and what will it deliver during 2008/09. If this has been a problem area for you in the past, how can you reduce these problems during 2008/09?
9. Identified risks and their management

- What were your main risks in 2007/08 and how did you mitigate/manage them? What have you learnt from this? What are the envisaged risks for 2008/09 and how will you deal with them?

10. Detailed funding requirements

- Probably best broken down by staff costs and non-staff costs.
- New bids/changes in the use of major funding streams should be clearly flagged – stating the resources required, the need, the risks if not funded and the expected benefits.

Appendix E – Annual Reports

Generic Annual Report Structure

Note:

This is a suggested generic structure for your annual report. We do not request that you follow this model slavishly, but that you use it as a template outlining what should be included in your annual report.

Introduction/executive summary

- ✓ An overview – your chance to say what has happened during the year – what went well and what went less well and what lessons you have learnt.

Performance against objectives

- ✓ This should refer back to your business plan for the period covered – how have you delivered against the targets/objectives you set yourself in your business plan?

Key challenges faced

- ✓ What were your key challenges and how did you tackle these – and where you could not resolve the challenge the key lessons learnt.

Successes achieved

- ✓ A chance to say what you have achieved during the period – but you may want to balance this against the resources required to deliver and any arising factors.

Key activity outputs:

Referrals

- ✓ The number of referrals received, the number processed and the number accepted for assessment. It would be good to have some basic data on where the referrals came from, the type of patient/prisoner etc.

Assessments

- ✓ This would be similar to the referrals information above.

Occupancy/intake (broken down by month)

- ✓ A great chance to tell us your occupancy levels, where people are (awaiting assessment, being assessed, awaiting treatment, in treatment, the nature of the treatment etc) and something about them (lifer, IPP, etc).

Treatment

- ✓ To include a brief summary of the treatment model and where patients/prisoners are in this process. This should refer back to your business plan predictions.

Progression

- ✓ Here is an opportunity to state the work that is on-going to facilitate progression and to raise any issues and report success stories. This section needs also address if any patients/prisoners have left the unit the reasons why and how they were “progressed”.

Statistical information

- ✓ This section should offer metric/statistical information on what you have “delivered” during the course of the business year.

Areas for improvement/development

- ✓ A chance to be as candid as possible – where you feel improvements could be made and how. This is an opportunity to say what additional skills, support and advice you may require to deliver on the improvement and/or development. However it needs to be recognised that additional programme-resources are extremely unlikely – this is more about how resources could be re-profiled to deliver the required results.

Lessons learned

- ✓ This should be seen as a chance to share lessons learned with others. This should look at things both clinical and organisational. The intention is for the annual reports to be available to password-controlled readers via the DSPD Intranet site.

Research and data

- ✓ An opportunity to say what has happened on the research front in your unit, both internally and with regard to the wider research. It is also a place to feedback how you are performing against the collection and collation of the Common Data Set.

Finances

- ✓ An opportunity to report how actual expenditure equated (or not) to your business plan – please break down by quarterly reports as well as the overall annual report.

Workforce Issues

Staff profile

- ✓ Who is in the unit – and data here on age profiles, ethnicity, disability etc would be very useful.

Recruitment

- ✓ An opportunity to tell us about your successes (and on-going problems) in recruitment and what works well and less-well on this front.

Vacancies

- ✓ The other side of the coin – where are your current vacancies and where are you experiencing problems in filling these.

Learning and development

- ✓ What programmes have you undertaken and what are the ensuing benefits? There is a need to ensure we are gaining benefits from the L+D we are undertaking.

Succession planning

- ✓ What is your strategy on succession planning?

Governance arrangements

- ✓ What governance arrangements do you have for your unit?

Security and risk management

- ✓ This can look at both what you have done to ensure you are running a secure unit and what security incidents have occurred during the period under report. This is an opportunity to share lessons learnt with the reader. Your overall risk register for the year should be included here.