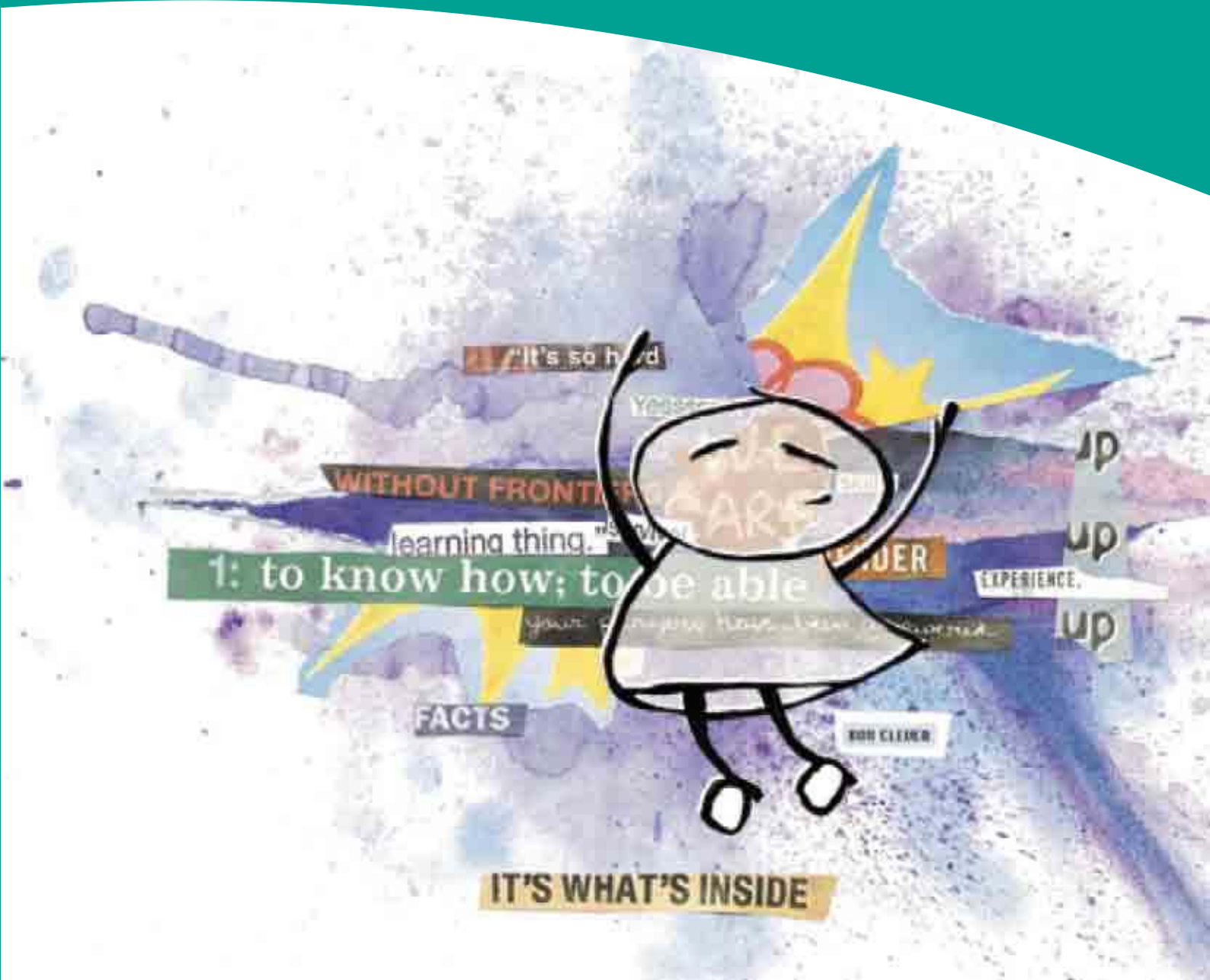


# Personality Disorder Capacity Plans 2005



# Personality Disorder Capacity Plans 2005

**Report on capacity planning exercise undertaken by catchment groups,  
specialised commissioning groups and NIMHE regional development, 2005**

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<b>Contact details</b>	Debra Clarke Department of Health Wellington House 133-155 Waterloo Road London SE1 8UG 020 7972 4751
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# Contents

<b>Foreword</b>	<b>2</b>
<b>Executive summary and summary of recommended action</b>	<b>3</b>
<b>1. Introduction</b>	<b>18</b>
<b>2. Approaches to capacity planning</b>	<b>20</b>
2.1 How commissioners have approached the task – geography	20
2.2 How commissioners have approached the task – focus	21
2.3 How the plans have been developed	23
2.4 Key themes	24
2.5 Lessons for the future	25
<i>Action recommended</i>	27
<b>3. Current services for people with personality disorders</b>	<b>28</b>
3.1 Current service provision identified in capacity plans – by tier	29
3.2 Identified gaps in current services	36
<i>Action recommended</i>	40
<b>4. Service models and treatments/interventions</b>	<b>41</b>
4.1 Treatment philosophy, approach and values	41
4.2 Service models	41
4.3 Treatment approaches	42
<i>Action recommended</i>	43
<b>5. Workforce issues</b>	<b>44</b>
5.1 Service development and workforce implications	44
5.2 Rationale for estimating costs	46
<i>Action recommended</i>	57
<b>6. Service user and carer participation</b>	<b>58</b>
<i>Action recommended</i>	58
<b>7. Development proposals and resource implications</b>	<b>59</b>
7.1 General comments and development proposals	59
7.2 Service development proposals	60
7.3 Organisational development proposals	62
7.4 Other proposed action	63
7.5 Investment implications	63
<i>Action recommended</i>	65
Appendix 1 – Capacity plans, geographical coverage	66
Appendix 2 – Current services, geographical mapping	69
Appendix 3 – Summary of service models, treatments/interventions	97
Appendix 4 – Financial investments proposed	104

# Foreword

In 2004, I reported on the progress achieved in implementing the vision set out in the *National Service Framework for Mental Health*.

In that report I referred to the publication of the guidance *Personality disorder: No longer a diagnosis of exclusion*; the investment in new pilot personality disorder services across the country; and the training initiatives to support the workforce in working with people with personality disorders. Those developments started the process of improving services for this challenging client group.

During 2005, commissioners, clinicians, service users and other stakeholders around the country have worked together to produce personality disorder capacity plans for their local areas. This report provides:

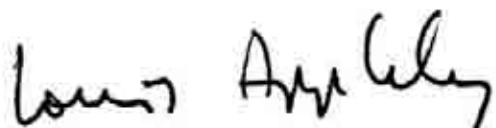
- a national overview developed from analysis of the plans;
- commentary on common themes;
- a summary of actions arising from the plans.

In reading this material, I am impressed at the effort and commitment the exercise has demonstrated, and with the valuable learning and data it has produced.

These plans represent a very important further stage in the process of improving services for people with personality disorder. They also underline the need for action in many of the areas identified in my report on the *National Service Framework Five Years On*. For example, I identified services for people with dual diagnosis of mental illness and substance misuse; social exclusion in people with mental health problems; the availability of psychological therapies; workforce redesign and development; out-of-area placements; and suicide rates in prisons as key areas for further work and action.

These issues are again highlighted in the capacity plans, demonstrating that progress in improving services for people with personality disorder will make a significant contribution to implementing the vision set out in the National Service Framework.

This report makes clear that the agenda of further work is challenging. Nonetheless I am confident that the Government's continued high priority on mental health and your commitment will ensure real achievements in improving services for people with personality disorder over the next five years.



Professor Louis Appleby  
National Director for Mental Health

# Executive summary and summary of recommended action

## 1. Introduction

In November 2004, Regional Secure Psychiatric Services Commissioners and Personality Disorder Leads of the National Institute for Mental Health in England (NIMHE), were asked to work collaboratively to produce regional capacity plans for the development of personality disorder (PD) services. This initiative was launched jointly by the National Oversight Group (secure psychiatric services) and the National Personality Disorder Development Team.

This nationwide review of personality disorder services post publication of *Personality disorder: No longer a diagnosis of exclusion* is necessary to inform future policy and investment, and because of:

- recognition of growing demand for service provision;
- unequal and variable service provision;
- no commonly recognised basic standards regarding what services people with PDs should be able to expect;
- disparate and disconnected service developments;
- pressure on public services which have not been equipped to respond;
- separate planning/commissioning arrangements for forensic PD services; mental health community-based PD services; and specialised services (for example, Henderson Hospital).

It was envisaged that regional partners would work together to:

- agree the geographical basis for plans and involve stakeholders;
- map current services for people with personality disorder and clarify needs and services required;
- identify pathways and how individual services contribute to the whole system;
- assess the capacity of current provision and outline action required.

Some outline guidance was provided to regional partners and commissioners indicating that plans should cover mainstream mental health and criminal justice system and prison

services, as well as those services specifically provided for people diagnosable with PDs, and providing an outline tiered model for considering PD-specific services.

It was generally understood that these would be initial capacity plans and that further work would be needed to refine thinking and development proposals.

Nonetheless, the plans represent important learning, and provide local stakeholders and the Department of Health (DH) and Home Office with a firm foundation to take forward further work.

## 2. Key themes

There are some key themes which emerge from these plans, including:

- recognition of the need for a robust and coherent conceptual model to support PD capacity plans and strategy;
- the importance of partnership approaches across the many agencies involved in providing support to people with PDs;
- the need to develop appropriate and robust commissioning arrangements for PD services;
- the importance of engaging with primary care to support an improved response for people with PDs;
- the essential role of mainstream mental health services in providing for people with PDs;
- the importance of staff attitudes and skills within current mainstream services in ensuring appropriate provision for people with PDs.

There are also a number of important issues that are relatively neglected in these initial plans, including:

- most plans do not adequately consider needs and service provision models for people with PDs and substance misuse problems;
- few plans mention the needs of people with learning disabilities and PDs;
- the importance of service user participation is only briefly considered;
- few plans have provided a clear view of the workforce impacts of their proposals;
- few plans have referred to the needs of children and young people with early indications of emerging PDs.

Most plans consider forensic services, and those provided within general mental health systems, separately. It is important to remember that the policy guidance stressed the need for linkages and pathways between forensic and non-forensic services for people with PDs, as has been underlined recently by the findings of the Anthony Hardy Inquiry.

### 3. Current services

Because of the complex needs of people with PDs, a comprehensive range of services may contribute to their treatment, management and care. This includes a range of mainstream services as well as services specifically provided for people diagnosable with PDs.

Information on current service provision in the individual plans has been analysed by access to 13 areas of service corresponding to the 6 tiers of the outline DH model. This comprehensive categorisation provides a mapping of the range of services that people with PDs might need to access.

In general, we can observe that:

- service provision for people diagnosable with PDs is very sparse, both in terms of response from mainstream services and PD-specific services;
- no area has anything approaching an adequate level of provision across the range of potential service responses;
- some areas have identified very little current service provision of any kind;
- the needs of people with PDs are not routinely considered across the full range of mainstream mental health services;
- exclusionary practice still operates in many mental health services (secure, forensic and community services), and there is a need for a clear steer and guidance from the centre.

Comments were made in the plans regarding service gaps and other challenges. These include:

- continuing difficulties because of inconsistent diagnosis and coding of PDs;
- fragmented and poorly coordinated services;
- inadequate therapeutic resources to support recovery approaches;
- significant lack of skilled and experienced workers;
- need for change in attitude and approach by health, social care and criminal justice professionals;
- major training and development needs across mainstream mental health services;

- significant need for robust, coherent service and treatment models and care pathways;
- need to improve the commissioning arrangements for PD services and partnership working between agencies;
- lack of PD services for women;
- lack of PD services for black and minority ethnic (BME) communities.

We can also highlight a number of issues regarding current service provision at the identified tiers or levels of service.

#### **Tier 6 – Dangerous and severe personality disorder services**

- Generally, dangerous and severe personality disorder (DSPD) provision in prisons has not been identified in plans.
- There are concerns regarding pathways out of high-secure DSPD units.

#### **Tier 5 – Secure care and forensic services**

- There is no national access to PD-specific services in medium-secure settings.
- Only six units are providing PD-specific services at medium levels of security and access is limited to trust catchments.
- Mainstream medium-secure services vary considerably in their willingness and ability to provide for people diagnosable with PDs.
- Many plans clearly state that the strategy for the future will be to ensure provision within mainstream secure services rather than PD-specific services.
- There are indications of significant use of the independent sector, which remains outside of strategic planning arrangements. It is not clear whether this arises from strategic commissioning or as an unplanned response to poor local provision.
- Access to mainstream community forensic teams is very patchy for people diagnosable with PDs.
- The six national pilot services are the only identified forensic community services and hostel services specifically for people with PDs.
- Many plans comment that forensic services for people diagnosable with PDs tend to be fragmented and poorly coordinated.

#### **Tier 4 – Specialist inpatient services (non-forensic)**

- Most but not all plans identify the specialist inpatient services (Henderson Hospital and Main House, currently commissioned by the National Specialist Commissioning Advisory Group (NSCAG)) that are accessible to their area.
- Most plans indicate that commissioners intend to continue commissioning these services for a limited period following their return to NHS commissioning in 2006. However, most imply that this will not continue beyond 2007. There is, therefore, a real concern that a significant level of resource currently invested in these services may be lost to PD services when these limited funds are devolved to the NHS.
- In addition to the nationally commissioned services, five other inpatient services are identified. There are indications that at least one of these faces uncertainty regarding commissioning intentions for the future.

#### **Tier 3 – Intensive day services**

- Some 11 intensive day services (in addition to national pilot sites) are identified in plans. These largely provide Therapeutic Community (TC) model services or focus on therapeutic treatment regimes.
- Such services are not available in the majority of local areas covered by plans.

#### **Tier 3 – Access to acute inpatient care**

- Most plans indicate that people diagnosable with PDs can be high users of inpatient care, and some plans provide survey data quantifying use. Figures are difficult to compare but usage rates quoted vary between 1.5% and 16% of mental health bed use.
- Plans recognise that acute services do not easily manage people with PDs; that this results in significant rates of out-of-area placements; and that there is a need for specialist expertise in caring for people with PDs in acute units.

#### **Tier 2 – Community-based, PD-specific treatment and case management**

- In addition to the national pilot services, a number of service developments are identified around the country and several trusts have indicated that they are in the process of planning or developing new services. However, many are quite small-scale developments, probably driven by keen practitioners and treatment focused, rather than case management services.
- Despite growing commitment, community-based provision remains sparse. Where mainstream crisis and psychiatric liaison services are providing short-term care for people with PDs, there are no community services available for ongoing support.

## **Tier 2 – Access to mainstream community mental health and drug and alcohol services**

- Few plans thoroughly consider how well local drug and alcohol services are able to respond to people diagnosable with PDs.
- Most plans comment on access to mainstream community mental health services, and some quote figures for the use of such services by people diagnosable with PDs. Where figures are given, rates for people with PDs on community mental health team (CMHT) caseloads vary significantly from 10–50%.
- Generally, it is not clear which services are accessible and inclusive of people with PDs and what services this client group should expect to access.
- It is acknowledged that many psychological therapy services either exclude people with PDs or are organised in ways that make them effectively inaccessible (eg formal referral systems, long waits etc).

While the capacity plans show considerable evidence of growing interest and commitment to improving services for people diagnosable with PDs, it is clear that exclusion remains ubiquitous and that there has been limited progress since the publication of *Personality disorder: No longer a diagnosis of exclusion*. This must continue to be a priority for action.

## **4. Service models and treatments/interventions**

Not all plans make explicit statements about underlying treatment philosophies and values. Common themes are: promoting recovery; meaningful service user involvement in treatment and service development; reducing stigma; working across sectors to ensure a mindset that goes beyond ‘mental health’ and the NHS; promoting attachment, engagement and consistency; developing understanding of what lies behind behaviour; and recognising the need for long-term treatment and care planning.

For the most part, community-based services and secure and forensic services are considered separately within plans, indicating that planning groups conceptualise these as distinct service systems with distinct service delivery and therapeutic models.

When considering community-based services, the models most frequently discussed are the ‘hub and spoke’ concept and ‘managed networks’.

The clinical treatment approaches mentioned were in the main those given as examples in the policy guidance. Some plans gave no indications for specific approaches for clinical work.

## 5. Workforce issues

Delivering an appropriate service for people with PDs, either through mainstream services, or PD-specific services, requires a competent workforce and adequate staffing levels.

All the capacity plans reflect these essential requirements. However, although some staffing numbers are provided for proposed services, planning groups have not as yet started to look at the broader workforce impacts of ensuring response to people with PDs throughout mainstream mental health services and beyond. Therefore, broader workforce strategies are a future development task.

Most plans provide some consideration of training and education requirements however, and most propose developing a career/skill escalator based on *Breaking the cycle of rejection: The Personality Disorder Capabilities Framework*, which was published in November 2003. These build on current PD training programmes under way through NIMHE Regional Development Centres. There are, however, a number of difficulties:

- Local partnerships with workforce development confederations and directorates (WDCs and WDDs) to support longer-term planning and commissioning of training programmes are weak.
- National standards are needed to ensure consistently high quality across regional initiatives.
- Current programmes will need to be expanded to cover the needs of staff working at all six tiers of service provision.
- It remains unclear whether mainstream health, social care and criminal justice education programmes provide adequate training on PDs.

A range of training and education proposals are put forward in these plans, broadly covering the following:

- awareness education – multi-agency approaches for generalist staff groups;
- basic capabilities training – for mental health service staff, forensic service staff for PD-specific services;
- specific interventions training – range of psychological therapies, TC approaches, case management, day service capabilities;
- education and support for service users;
- education and support for carers;
- commissioning capabilities training.

For the most part, detailed costings have not been provided for training proposals. To assist in future planning, the National PD Development Team has estimated broad-brush costs for taking forward proposed training initiatives.

## 6. Service user and carer participation

Most plans acknowledge the need to facilitate and support active service user and carer participation.

This includes:

- service users, recovered service users and carers participating in the development of local and regional services;
- recovered service users working in new ways and new roles as part of the workforce for new PD-specific services;
- service users, recovered service users and carers contributing to training and education programmes to develop the capabilities of the whole workforce.

Proposals to develop robust regional service user and carer participation are now being implemented.

## 7. Development proposals and resource implications

These initial plans vary considerably in terms of strategic thinking and clear proposals for service developments. Capacity plans that cover the needs of a total population at all levels are, for the most part, some way off.

Further work will be necessary on some issues, for example developing models appropriate to urban and to rural settings.

Although there is an awareness of potential demand from prisons and forensic populations, proposals for these client groups are less well developed. Separate high/medium-secure capacity planning exercises being undertaken by catchment groups may clarify the picture.

Development proposals put forward in the plans cover: direct service developments, organisational developments, and other required action to improve understanding and knowledge and progress planning.

Direct, PD-specific service development proposals include:

At Tiers 5/6

- inpatient assessment and treatment in medium and low-secure settings;

- secure PD services for women;
- step down and community forensic PD services;
- intensively supported accommodation for step down from high and medium-secure services;
- in-reach to prison and prison-based assessment and treatment services.

At Tiers 3/4

- inpatient and intensive day service assessment and treatment.

At Tiers 1/2

- PD-specific 'hub and spoke' community services with intensive case management;
- specialist multidisciplinary and 'virtual' PD teams;
- early intervention and crisis response services and specific treatment (eg dialectical behaviour therapy (DBT)) teams;
- complex needs services;
- hostel/accommodation services;
- increased psychology and counselling in primary care;
- enhancements in substance misuse services;
- self-help and user-led initiatives;
- carer support services;
- PD early intervention services;
- a range of PD prevention, particularly for children and young families;
- specialist PD workers in primary care.

Organisational development work proposed includes:

- PD network and forum developments;
- review, redesign and reconfiguration of current PD and mental health services;
- auditing existing provision for effectiveness;
- review of access criteria for mental health services;
- improving commissioning arrangements and strengthening partnerships;

- identification of PD leadership in trusts;
- developing and agreeing pathways of care;
- implementation of a 'whole system' approach to service planning and delivery;
- agreeing local PD strategies;
- strengthening links between forensic and non-forensic services;
- making links into prisons and supporting prison discharge;
- establishing PD Expert By Experience programmes;
- actions to retain the existing specialist PD workforce;
- creation of a single organisation for forensic psychological care;
- establishment of a PD Institute.

Other proposed development work mostly relates to completing the capacity planning process and establishing PD in the mainstream of mental health services and within a wider spectrum of public services, including:

- continuing work on the wider development of PD-related services including learning disabilities, children and adolescents, older people and BME communities;
- further needs assessment, gap analysis and improvement in local data;
- developing clearer evidence-based models of treatment;
- improving voluntary sector links;
- improving support to housing agencies;
- promoting service user evaluation;
- working with DSPD services to design and develop PD services;
- developing a specification for prison in-reach to identify an adequate response to PD needs;
- redesign of accident and emergency (A&E) responses to deliberate self-harm;
- consideration of NHS and private sector development options;
- assessing the potential impact of DSPD and the Mental Health Bill on local service demand.

Most service proposals have not been costed, so to assist in future planning, the National PD Development Team has estimated costs where necessary.

## 8. Conclusions

While further work is needed, the capacity plans provide important learning and a firm basis for both DH and local stakeholders to take planning forward.

The total of identified and estimated investment costs resulting is £27.1 million for service development for the period 2006–10, and £3.6 million for training and education for the period 2006–09.

Outline resource requirements were abstracted from these plans to inform DH financial planning discussions in early summer 2005. However, given the comprehensive review of DH and NHS financial profiles currently under way, at this stage, we do not anticipate additional investment resources for the development of PD services prior to 2008/09. Careful consideration will therefore be needed to clarify the timetable for ongoing work. It is also important that all agencies consider how they use current resources, for example through redesign initiatives, to improve the service response to people with PDs. New funding for PD was included within all primary care trust (PCT) baselines in 2004/05 and 2005/06.

It is also clear that a significant programme of work is needed before detailed development proposals might be considered for investment.

Not least, a comprehensive range of action will be necessary to ensure that mainstream community and secure mental health services provide appropriate care for people diagnosable with PDs.

Finding the levers and incentives to achieve this major culture shift should be a priority for action. Many mental health services are currently undergoing various forms of modernisation or re-engineering. Ensuring that the response to people with PDs is considered within such exercises will both advance equitable access to services and contribute significantly to reducing inappropriate bed use, out-of-area placements and ‘ricochet’ around the system in crisis situations.

In this context it may be helpful to use a PD-focused version of the National Service Framework (NSF) mental health standards, as below.

## Mental health services – Standards for people with PDs

<b>NSF Standard 1</b>	Mental health promotion – understanding of the potential impact of programmes for healthy neighbourhoods, communities and families on the development of PD; appropriate planning forums (eg Local Strategic Partnerships), engaged and aware of PD perspectives; PD addressed in programmes to reduce stigma and discrimination
<b>NSF Standard 2</b>	Within primary care services, identification, assessment and management (with support) of less severe and disabling PDs, and referral on to specialist services where appropriate; jointly developed protocols for the management and treatment of PD across primary/secondary care
<b>NSF Standard 3</b>	Access to information and advice for people with PDs Contact with relevant services round the clock and access to appropriate services in crisis
<b>NSF Standards 4 and 5</b>	Effective services for people with more serious/complex PDs: engagement; crisis management; Care Programme Approach or other care planning/coordination as appropriate; appropriate residential treatment/care if necessary; effective participation of service users
<b>NSF Standard 6</b>	Advice, information, support for carers of people with PDs
<b>NSF Standard 7</b>	Preventing suicide in people with PDs; ensuring staff are appropriately trained and aware; appropriate support to A&E departments to facilitate response to PD

Local and specialist commissioners may wish to take quite different development approaches to ensuring that the needs of people with PDs are addressed. Promoting a consistent view of what people with PDs should be able to expect from services, should allow commissioners flexibility and local sensitivity in the service models they choose to use.

In relation to focused plans for the further development of services for people with PDs, the National PD Development Team will work closely with colleagues within DH and the Home Office to clarify a staged action plan for the further development of strategy, a forward investment plan and progress towards further stages of service development. These will be discussed at a national conference to be held in early 2006 which will also provide an opportunity to disseminate learning from the capacity plans and national pilots.

## Summary of action recommended

### Approaches to capacity planning

Action is recommended to:

- clarify and develop appropriate commissioning arrangements, experience and approaches for PD services;
- clarify and confirm with all partners the geographical planning basis prior to future strategic planning of PD services;

- further develop and refine the outline tiered model of PD services to support further planning and strategy development;
- initiate discussions with the Healthcare Commission, the Commission for Social Care Inspection (CSCI), and other performance monitoring bodies to ensure that review of mental health services adequately reflects provision for people diagnosable with PDs;
- initiate discussions with DH primary care policy teams, the National Association of Primary Care (NAPC), the Royal College of General Practitioners (RCGP) and others to explore potential models for primary care PD service provision, and how best to strengthen response to PD in primary care;
- ensure that learning from PD community pilots regarding substance misuse and PD is circulated to capacity planning groups as appropriate;
- initiate discussions with the Valuing People Team within DH regarding people with learning disabilities and PDs;
- scope capacity planning perspectives in relation to young people with emerging PDs;
- continue discussions with NIMHE, mental health workforce programme leads, and other stakeholders regarding the development of a workforce strategy for PD services;
- identify DH public health support to clarify preferred epidemiological approach and needs assessment methodology for future planning initiatives;
- investigate and plan for improved access to appropriate PD services for people from BME communities.

### **Current services for people with personality disorders**

Action is recommended to:

- support local commissioners and mental health trusts to ensure that people diagnosable with PDs can access services appropriate to need at medium, low and Psychiatric Intensive Care Unit (PICU) levels of security;
- ensure that the use of mainstream secure mental health services by people with PDs is adequately reflected in local activity monitoring;
- undertake further systematic analysis of out-of-area placements for people diagnosable with PDs;
- provide consistent information on the use of secure services by people diagnosable with PDs (within standard frameworks to be developed by the National PD Development Team);

- ensure that specialist and local commissioners are provided with regular information on the development and learning from the forensic community PD pilots;
- coordinate a brief piece of scoping work on potential residential service models for further consideration by capacity planning groups;
- ensure that the implementation of psychological therapy policy adequately reflects the needs of people diagnosable with PDs, and PD-specific service development;
- coordinate a workshop event on development of PD-specific psychological therapy services.

### **Service models and treatments/interventions**

Action is recommended to:

- ensure that commissioners, trust senior managers and other key postholders develop appropriate understanding of PDs and complex treatment approaches.

### **Workforce issues**

Action is recommended to:

- develop a model for projecting future workforce needs (roles and numbers) at all six tiers of service provision;
- sustain existing regional training developments and work with local commissioners to ensure that there is appropriate training to address regional and local gaps and to support the development and implementation of care pathways across all six tiers of provision;
- develop guidelines on the capabilities required to work with people with co-morbid PDs and learning difficulties, and commission and disseminate a relevant training package based on these guidelines;
- develop guidelines for commissioners of education and training for PDs;
- develop further guidance, linked to the Ten Essential Shared Capabilities (ESC), to underpin the future development of a national training and skills escalator for PDs;
- develop guidance on new ways of working within services for people diagnosable with PDs and their carers;
- develop pathways into meaningful employment within PD or mainstream services for recovering service users and carers;
- develop protocols to underpin service user and carer involvement in training.

### **Service user and carer participation**

Action is recommended to:

- sustain and extend existing national and regional structures for user and carer participation;
- consider specifically the needs of carers of people diagnosable with PDs and bring forward guidance on their requirements for services.

### **Service development proposals and resource implications**

Action is recommended:

- While future investment timescales still remain unclear, we continue to anticipate consideration of development proposals for investment in 2008/09. Local stakeholders may therefore wish to refine suggested service developments described in these capacity plans into detailed and costed implementation plans to meet this outline timetable.

# 1. Introduction

In November 2004, regional secure psychiatric services commissioners and personality disorder leads from NIMHE were asked to work collaboratively to produce regional capacity plans for the development of PD services. This initiative was launched jointly by the National Oversight Group (secure psychiatric services) and the National PD Development Team. It was envisaged that these regional partners would work together to agree the appropriate geographical basis for local plans, and to design a planning process which would effectively involve the relevant stakeholders.

Initiating a nationwide review of PD services is necessary to inform future policy and investment because of:

- recognition of growing demand for service provision;
- unequal and variable service provision – no commonly recognised basic standards regarding what services people diagnosable with PDs should be able to expect;
- disparate and disconnected service developments;
- separate planning/commissioning for forensic PD services, mental health community-based PD services and specialised services (both currently and in the future);
- and, to inform future policy and investment.

It was expected that plans would:

- map current services for people diagnosable with PDs;
- clarify patterns of need/demand and the range of services required;
- identify pathways and how individual services contribute to the whole system;
- assess the capacity of current provision;
- outline medium and longer-term objectives.

It was intended that the outputs from the planning exercise would be collated and analysed over the summer of 2005, in preparation for higher policy-level discussions within DH in autumn 2005, and for a further stage of iterative strategy development and implementation work at national, regional and local levels, from late autumn 2005.

We recognised from the outset that producing PD capacity plans would be a challenging task for local health and social care communities. PD remains a difficult subject, with poor information sources, poor and inconsistent identification and diagnostic practice, and underdeveloped needs assessment methodologies. A truly comprehensive exercise would need to engage with a very wide range of agencies across many sectors and all age groups

We were, therefore, very clear with commissioners that these plans would be regarded as initial or outline documents, with the expectation that further work would be necessary to round out the picture and provide essential detail on proposals.

This expectation has been borne out, with many plans identifying that significant further work is needed. Nonetheless, these plans provide important information about current services, patterns of need and the overall direction in which stakeholders would like to see services develop.

This report provides:

- collated summaries of information from the individual capacity plans;
- analysis and commentary on key themes;
- an overview of the resource implications of the plans;
- recommendations for further action arising from the plans.

# 2. Approaches to capacity planning

## 2.1 How commissioners have approached the task – geography

As mentioned above, in view of the potential complexities of this exercise, it was left to local partners to agree the appropriate geographical basis for capacity plans. Plans are therefore based on a variety of geographical or planning units, including single strategic health authority (SHA), single local specialised commissioning group (LSCG), whole specialised commissioning group (SCG)/catchment group and counties.

Appendix 1 provides a detailed breakdown.

There are some anomalies; for example, the Thames Valley plan is nominally for the LSCG covering Swindon, which is in fact covered within the report for Avon, Gloucester and Wiltshire.

Also, there is considerable variation in the size of populations covered by the plans.

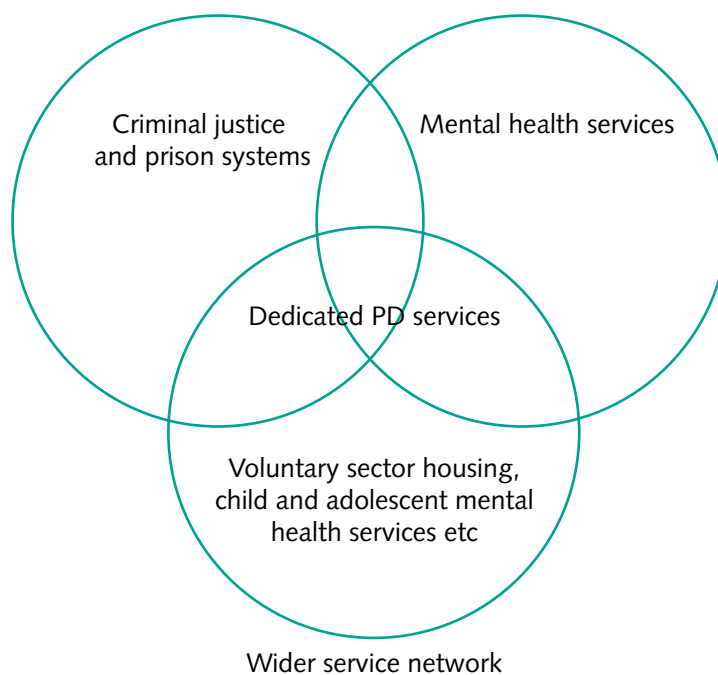
Table 1: Capacity plans – populations	
Capacity plan	Population covered (millions)
South West Peninsula	1.5
Kent, Surrey, Sussex	2.5
Avon, Gloucester, Wiltshire	1.6
Eastern	4.6
North West	4.9 (adults)
East Midlands	5.4
West Midlands	5.3
Northern	2.7
Thames Valley	2.1
London	7.2
Dorset and Somerset	0.5
Yorkshire	3.7

## 2.2 How commissioners have approached the task – focus

It was also intended that plans should address both forensic and non-forensic services as these have previously been considered separately. An outline planning model was circulated to planning groups, which indicated six tiers of service provision that plans should address. Key points from a PowerPoint presentation summarising the guidance are shown below.

### Excerpts from 'Personality disorder: strategic commissioning' (PowerPoint presentation circulated to capacity planning groups, January 2005)

#### Towards a strategic model for personality disorder services



#### Developing a tiered approach for PD-specific services

**Tier 6** DSPD pilot services

**Tier 5** Secure and forensic PD services – units and treatment programmes for people diagnosable with PDs within medium and high-secure services and associated community services

**Tier 4** Specialised inpatient and intensive services for those people whose problems cannot be managed/treated at local level (Henderson Hospital, Main House, North West PD Service)

**Tier 3** More intensive day services with treatment, case management and crisis support

**Tier 2** Appropriate range of community-based individual/group treatment programmes, case management, access to crisis support

**Tier 1** Focused support to the wider service network

**A 'whole system' approach should consider:**

- the wider service network (housing, A&E, primary care, National Offender Management Service etc) – what focused support (such as joint case work/supervision) is needed to strengthen capacity?
- how mainstream mental health services can be strengthened (eg training and staff development, PD-focused posts, improved liaison with dedicated PD services etc);
- what dedicated community PD services are needed (eg range of therapies available, case management and treatment and/or intensive day services);
- what PD-specific forensic services are needed (eg at low, medium and high-secure levels; within prisons and probation services; and outreach, post-treatment, rehabilitation and community support services);
- how to ensure pathways in and out, and between, services are smooth and simple;
- how to ensure training and staff development contribute to all levels of capacity building.

Table 2 summarises how plans have addressed the request to cover both forensic and non-forensic issues.

Some areas have undertaken capacity planning alongside other planning processes that had been initiated or commissioned earlier. Thus London SHAs have been working collaboratively on a PD strategy or framework since summer 2004 and this work was completed in autumn 2005. The London Capacity Plan therefore does not put forward a fully detailed desired service model or comprehensive costed development proposals at this stage, although a number of recommendations for action are made.

Across the South Catchment Group, prior to the request for capacity plans, work was initiated on a review of specialised PD services, ie services for people with severe or complex PDs (and therefore not addressing Tiers 1–3 of the outline DH model). However, this approach is supplemented by the more community-based approaches of the plans for the smaller geographical units within the South Catchment Group.

On the whole, this flexible approach to geographical and planning bases has worked reasonably well, despite anomalies already referred to.

The variations in approach highlight the difficulties of developing appropriate commissioning arrangements and structures for PD services. Commissioning for this client group cuts across current arrangements, ie of catchment groups for some secure services and collaborative arrangements for others; LSCG and SCG arrangements for commissioning specialised services; local mental health commissioning on a PCT basis; and separate commissioning systems for local offender management services.

Currently, some work is under way within SCGs to consider arrangements for commissioning specialist mental health services. In the light of that work, we have asked SCGs for their views as to the best or desired arrangements for commissioning PD services. Further work will be needed to ensure effective commissioning for this client group within the complex context that prevails.

**Table 2: Capacity plans – topic coverage**

	<b>Integrated</b>	<b>Forensic only</b>	<b>Non-forensic only</b>
West Midlands	✓		
Eastern	✓		
Devon, Plymouth and Cornwall	✓		
North West	✓		
Northern	✓		
Kent, Surrey, Sussex		✓	
London	✓		✓
Yorkshire	✓		
East Midlands and South Yorkshire	✓		
Dorset and Somerset SHA			✓ Tiers 1–3
Thames Valley and Swindon			✓
Avon, Gloucester and Wiltshire			
South SCG specialised personality disorder		Covers severe PD, DSPD, forensic and specialised inpatient services	
South SCG forensic capacity plan		✓	

### 2.3 How the plans have been developed

Most commissioners have used a variety of methods to draw up the plans. These have included:

- questionnaires to PCTs, trusts and non-health service agencies;
- analysis of activity and other quantitative data from a variety of sources;
- specific surveys (for example, of clients with PDs on community mental health service caseloads);
- workshops and discussion sessions to bring together a wide range of stakeholders, including PD service users.

It is important not to lose the beginnings of networking, collaboration and partnership across complex service systems and stakeholders that have developed through the capacity planning exercise.

Most plans have included some epidemiological analysis of need, but as these have been undertaken on differing bases, comparison is difficult and this highlights a more general problem in relation to robust needs analysis for this client group. The National Team will seek some public health expertise in analysing the material provided and in suggesting a consistent way forward.

Several plans have also attempted to clarify current levels of spending (both planned and unplanned) on PD. This includes estimated spend on out-of-area placements and acute psychiatric care, with the implication that such resources could be used in better, planned ways for more appropriate care. While it is not made explicitly clear in most plans, it is evident that commissioners are facing very difficult financial scenarios with significant challenges in identifying investment resources for PD.

## 2.4 Key themes

There are some key themes that emerge from these plans, including:

- Both from comments made in the plans and from the way in which plans have developed, it is apparent that there is a clear need for a robust and coherent conceptual model to support PD capacity planning and strategy development.
- All plans stress the real importance of partnership approaches across the many agencies involved in providing support to people diagnosable with PDs. This raises the question as to whether there may be a potential role for local strategic partnerships in the planning and commissioning of services for people diagnosable with PDs. This may prove to be of particular importance when capacity planning groups start to consider issues of prevention and addressing the social determinants of PD.
- The need for further development of commissioning arrangements, systems and culture has already been commented on.
- The potential importance of engaging with primary care and supporting an improved response from primary care for people diagnosable with PDs is frequently commented on. Several plans also note that, where services for people diagnosable with PDs are underdeveloped or mainstream services operate exclusion criteria, the response from primary care is particularly important. However, only one plan puts forward development proposals specifically focused on primary care. The one PD community pilot that has a dedicated primary care element is not as yet able to provide learning about models and development issues in this service area, so further work will be necessary.

- Either explicitly or implicitly, all plans stress the importance of mainstream mental health services in providing for people diagnosable with PDs. However, it is not clear that the needs of people diagnosable with PDs have been routinely considered within all the services that now make up a comprehensive, whole-service system. It is also clear that exclusionary practice still operates in many services and that there is a need for a clear steer and guidance from the centre.
- Most plans stress the importance of staff attitudes and skills within current mainstream services in ensuring appropriate provision for people diagnosable with PDs. This underlines the necessity for fully developed and resourced training programmes which are only patchily provided within these initial plans.

There are also a number of important issues that are relatively neglected in these initial plans and where we may need to seek or provide informed or expert support. For example:

- Generally, the plans do not adequately consider needs and service provision models for people diagnosable with PDs and substance misuse problems. It may be possible to disseminate some learning from the community PD pilot which specifically focuses on this area.
- Only a few of the plans mention needs of people with learning disabilities and PDs. This may be an area where the National Team could usefully seek some support from the Valuing People Teams within DH.
- The importance of service user participation is only briefly touched on although it is clear that some plans have been developed with significant involvement.
- Overall, there appears to be a real lack of workforce planning skills available to capacity planning groups, and few plans have provided clear statements and costs for the workforce impacts of their proposals.
- Some, but not all plans have referred to the needs of children and young people with early indications of developing PD.
- Few plans consider the need to develop new roles and new ways of working in relation to services for people diagnosable with PDs.

## 2.5 Lessons for the future

While most plans still have some way to go in terms of setting a direction of travel or proposing clear service developments, the process of developing these initial plans has been valuable. It has raised the profile of PD services and started to establish partnerships across agencies that have not previously worked together, or have not worked together on PD issues. The service user involvement has proved positive and, alongside a number of other

service user developments, we are starting to see more clearly articulated service user views and embryonic networking across the country.

The plans provide both local stakeholders and DH with a firm foundation and significant data from which to take forward more detailed planning work.

We recognise that the process set up by the National Oversight Group and the National PD Development Team had some flaws.

Despite providing funding, most participants still found the timescale short given the complexity of the task, and indeed it was extended by a month.

Involving catchment groups and NIMHE PD leads was an attempt to ensure that planning processes engaged those stakeholders with knowledge of both the more intensive and high-risk end of the need spectrum, as well as those common and disabling presentations which are less severe but at a much higher volume.

In the event, this meant people forging new relationships across agency boundaries; some confusion for many people as to how to proceed; rather patchy NIMHE involvement; and plans developed on a wide range of bases.

Prior to the next phase of planning activity, it will be helpful to discuss and confirm with SHAs, catchment groups and NIMHE Regional Development Centres, the optimum bases for PD capacity planning.

It is also clear that the outline planning model, as provided by DH, is not sufficiently developed for the task. It has proved helpful in outlining the scope of the material needed, systems to be covered, and stakeholders to engage; and the tiered model has been used in various forms in most plans. However, few plans have managed to use the model to comprehensively cover the full scope of overlapping systems; its use has highlighted areas for amendment; and, as noted above, there were several comments made about the need for robust, comprehensive conceptual models to support the development of strategy.

Prior to the next phase of planning activity, the National PD Development Team will refine the outline model; summarise what learning can be drawn from the existing plans as to models and frameworks; and investigate what other planning tools or schema might support commissioners in the task.

As indicated above, and in other parts of this report, the plans demonstrate a number of topics where some further development or scoping work could support catchment groups and their partners in continuing to build their capacity plans. Where possible, the National

Team intends to take forward time-limited project work on such topics and feedback the results to capacity planning teams.

## Action recommended

Action is recommended to:

- clarify and develop appropriate commissioning arrangements, experience and approaches for PD services;
- clarify and confirm with all partners the geographical planning basis prior to future strategic planning of PD services;
- further develop and refine the outline tiered model of PD services to support further planning and strategy development;
- initiate discussions with the Healthcare Commission, CSCI, and other performance monitoring bodies to ensure that review of mental health services adequately reflects provision for people diagnosable with PDs;
- initiate discussions with DH primary care policy teams, NAPC, RCGP and others to explore potential models for primary care PD service provision, and how best to strengthen response to PD in primary care;
- ensure that learning from PD community pilots regarding substance misuse and PD is circulated to capacity planning groups as appropriate;
- initiate discussions with the Valuing People Team within DH regarding people with learning disabilities and PDs;
- scope capacity planning perspectives in relation to young people with emerging PDs;
- continue discussions with NIMHE, mental health workforce programme leads, and other stakeholders regarding the development of a workforce strategy for PD services;
- identify DH public health support to clarify preferred epidemiological approach and needs assessment methodology for future planning initiatives;
- investigate and plan for improved access to appropriate PD services for people from BME communities.

# 3. Current services for people with personality disorders

Because of the wide-ranging needs of people diagnosable with PDs, a very comprehensive variety of services may contribute to their treatment, management and care.

Section 3.1 below summarises the current service provision that has been mapped in the individual plans, by access to 13 areas of service corresponding to the 6 tiers of the outline DH model. This comprehensive categorisation attempts to provide a mapping of the range of services that people diagnosable with PDs might expect to access.

Table 3: Current service provision by tier		
Tier 6	DSPD – access to high-secure PD services	(PD dedicated)
Tier 6	DSPD – access to prison-based PD services	(PD dedicated)
Tier 5	Forensic – access to medium and low-secure PD services	(PD dedicated)
Tier 5	Out-of-area placements (forensic) for people diagnosable with PDs	
Tier 5	Forensic – access to specialist hostels	(PD dedicated)
Tier 5	Forensic – access to community teams	(PD dedicated)
Tier 5	Forensic – access to mainstream community teams	
Tier 5	Prison services – access to PD-specific services	(PD dedicated)
Tier 4	Non-forensic – access to <b>specialist</b> inpatient services	(PD dedicated)
Tier 3	Non-forensic – access to intensive day care services	(PD dedicated)
Tier 3	Other forms of residential care for people diagnosable with PDs – either NHS or voluntary/independent sector	
Tier 3	Access to mainstream acute psychiatric care	
Tier 2	Access to PD-specific community health services/casework etc	(PD dedicated)
Tier 2	Access to any PD-specific, offence-related, community CJS services/casework etc	(PD dedicated)
Tier 2	Access to mainstream health, mental health, and drug and alcohol services	
Tier 2	Access to mainstream NOMS services	
Tier 1	Access to assessment, early identification, referral on, management in/through primary healthcare	
Tier 1	Access to any PD-specific, or mainstream, social care, housing, employment services, police interventions	

This includes both dedicated PD services and those mainstream services which are accessible by people diagnosable with PDs, among other client groups. Some psychological therapy

services (such as DBT services and dynamic psychotherapy units) may not be designed as PD-dedicated services, but are likely to be used by significant numbers of people diagnosable with PDs.

From the pattern of service provision reported across the country, a number of comments can be made.

Firstly, in general, most of the service provision reported in the plans looks relatively sparse. This is partly because further detailed planning work remains to be done. But also we suspect that it is a realistic picture of very patchy service provision across the country.

Secondly, on the whole, less information is provided in relation to services for prison populations and offenders with PDs.

### 3.1 Current service provision identified in capacity plans – by tier

#### **Tier 6 – Dangerous and severe personality disorder**

There is no information reported in plans regarding DSPD provision within prisons. While the existence of the DSPD programme is acknowledged in most plans, the reference is generally to the two developing services in the high-secure hospitals at Rampton (Peaks Unit) and Broadmoor (Paddocks Centre).

The two prison pilots at Whitemoor and Franklin prisons and the women's DSPD service at Lower Newton are not identified.

Generally, the question of pathways out of DSPD are raised as an important factor for future planning which will need to ensure step-down services are available. However, the responsibility for these services is seen by some to be more criminal justice than health focused.

#### **Tier 5 – Secure care**

Overall, only six units across England are providing dedicated PD services at medium levels of security. These are the four national pilots (South London and Maudsley, Nottinghamshire, East London and Newcastle), Arnold Lodge in Leicester and Stockton Hospital in York.

While some plans provide figures of identified patients with PDs using secure services, most do not, and the figures provided are produced on a range of bases making comparison difficult. From the information available, it is clear that mainstream secure services vary considerably, with some treating significant numbers of people diagnosable with PDs, and

some treating few or none. Thus several plans note that people diagnosable with PDs who need treatment in secure settings tend to be placed out of area.

Without comprehensive information, it is difficult to assess need or to discuss potential and optimum models for service provision.

In the next stage of capacity planning, it will be important to ensure a consistent approach to measuring secure service use by patients with PDs.

Several plans comment that their agreed strategic direction is to develop integrated secure services providing for people diagnosable with PDs and those with mental illnesses. While this approach may be supported by DH, it will be important to ensure that such services are **really** accessible to people diagnosable with PDs; that treatment and management approaches are developed which are appropriate to the different needs of the client groups; and that such policies do not result in a postcode lottery of service provision for people diagnosable with PDs.

#### **Tier 5 – Dedicated forensic community services for people diagnosable with PDs**

Currently, the only such provision is the six pilot services which are providing a range of service elements including specialist community teams and supported housing. These are only patchily reported in capacity plans, indicating that commissioners may not know of them, or be learning from them how such models might potentially impact on local need and service systems. While these services are as yet embryonic and the national evaluation study is still in progress, specialist commissioners should be aware of them as they will inform future commissioning of Tier 4 and 5 provision.

#### **Tier 5 – Access to mainstream forensic community services**

Several plans identify mainstream forensic community teams although there is virtually no information regarding the use of such services by people diagnosable with PDs:

- For Cornwall, a DBT service linked to the forensic community team is identified, and this interesting model would presumably be accessed by significant numbers of people diagnosable with PDs.
- In the North West plan, it is noted that for one community forensic team, 13 clients with PDs had been identified on the caseload.

#### **Tier 4 – Specialist inpatient services**

There are relatively few such services: the Henderson; Main House; Cassel; Crisis Recovery Unit, Maudsley; St Andrews DBT Unit; The Retreat, York; and Francis Dixon Lodge.

Two services are provided by the units currently commissioned by NSCAG (Henderson Hospital and Main House). These services will devolve to NHS specialist commissioning in 2006, and currently 'steady state' commissioning, on geographical catchment basis, has largely been agreed for 2006/07. Nonetheless, not all plans mention the service relevant to their area, and where they are discussed, there is little information about patterns of use and how they address local need. Specialist commissioners are still in the process of building their understanding of how such services are currently used and how in the future they should best be used to address need, or indeed whether they should continue to exist. They are expensive services (cost per case prices in the region of £90,000–100,000) and it is therefore understandable that some local commissioners have indicated a preference to use the devolved resources to develop local services in the medium-term future.

However, at a national level, we do not as yet have an understanding of how the demand for these services might change as local services are developed, or what the longer-term need for inpatient services might be. Experience from the North West, where Webb House closed its residential beds in summer 2004 and is developing intensive day-care services in different localities, may be helpful. This indicates that there is some residual demand for inpatient services as both Henderson Hospital and Main House received referrals from the North West during 2004/05.

At the same time, in one capacity plan (Thames Valley) the need for some kind of local residential facility is raised. There are, therefore, a number of questions arising concerning future need and models of service delivery for residential services.

### **Tiers 5 and 3 – Out-of-area placements**

Several plans mention out-of-area placements for people diagnosable with PDs. Although it is clear that commissioners are struggling with incomplete information about these placements, most believe that the number of placements is high with significant cost to their economies.

While information is scarce, it is clear that some placements are due to local acute inpatient services not being able to manage individuals with PDs, and some are due to demand for treatment in secure settings:

- The East Midlands plan identifies nine PD patients on forensic independent sector placements.
- The North West plan notes 68 PD patients in out-of-area placements in December 2005 representing 3.8% of all placements.
- The Northern plan reports five placements for PD patients for three PCTs.

Out-of-area placements may be made for many different reasons and frequently information systems are not able to capture the reason for the placements. For people diagnosable with PDs, it would be helpful to know whether such placements are largely to address challenging behaviours; to provide specialist treatment on a residential basis (eg for eating disorders or obsessive-compulsive disorder and PD); to provide access to independent sector Therapeutic Communities or slow-stream rehabilitation services; or whether they are mainly for people diagnosable with PDs who need treatment within a secure setting.

A better understanding of such placements would support effective capacity planning for secure services for people diagnosable with PDs, and assist in estimating the future need for specialist inpatient services such as those discussed in the previous paragraph.

### **Tier 3 – Access to mainstream acute inpatient care**

A number of plans indicate that people diagnosable with PDs are significant users of acute psychiatric care. For the most part, commissioners are struggling with little hard information, but occasionally data are given based on specific surveys or census initiatives. Where these are noted, the figures vary considerably:

- 16% of acute mental health beds used by people diagnosable with PDs (Surrey and Sussex).
- There are varying rates of between 1.4% and 5.15% of acute psychiatric and forensic admissions for people diagnosable with PDs (East Midlands and South Yorkshire).
- For Thames Valley, it is noted that 4–5% of psychiatric admissions are people diagnosable with PDs.

As estimates have been drawn up on different bases, it is difficult to draw conclusions.

### **Tier 3 – Intensive day services for people diagnosable with PDs**

Other than the national pilot services that provide intensive day care, a number of other day services are identified (most of these, but not all, are clearly identified as dedicated PD services):

- in London, the Cawley Centre, Pine St Day Centre, Halliwick Day Centre, Waterview Centre and Homerton Day Programme;
- in Kent, the Brenchley Centre;
- in Somerset, a three days per week psychotherapy day service for people diagnosable with PDs;
- in the North West, the Rotunda, Fifteen and Red House day services (linked to Webb House and Therapeutic Community Services North);

- in Watford, the Shrodells Unit;
- in the Thames Valley, Winterbourne House;
- in Yorkshire, Diverse Pathways, in partnership with Therapeutic Community Services North.

Some of these services are long established and well known, but others have been developed relatively recently and it is encouraging to see a number of such developments given that this type of provision can be relatively costly. Nevertheless, such services are available in a minority of areas.

In the areas where such services are established, it will be important to see the development of Tier 2 services so as to ensure effective pathways and the optimum use of intensive services.

## **Tier 2 – Access to mainstream health, community mental health, and drug and alcohol services**

As we have noted elsewhere, issues relating to primary care provision for people diagnosable with PDs; and issues relating to drug and alcohol services are not discussed in detail within these plans, although they are clearly very important. Therefore, the majority of this section concerns access to mainstream mental health services

In several plans, for areas where there is no dedicated PD community service, it is noted that access to assessment and treatment is through the mainstream community mental health services. A few plans (eg Dorset and Somerset) specifically note that eligibility criteria for mainstream mental health services are inclusive of PD but most do not, so it is not clear how accessible services are in some areas.

Some plans have quoted figures for the use of community mental health services by people diagnosable with PDs, usually based on specific survey or census initiatives. Where these are noted, the figures vary considerably:

- People diagnosable with PDs are estimated to comprise varying rates from 10% to 50% of CMHT caseloads (North East).
- People diagnosable with PDs comprise 30% of CMHT caseloads (Bury, North West).
- For one PCT, people diagnosable with PDs comprise 8–10% of CMHT caseloads (Northern).

So, it is difficult to draw conclusions.

In general, we need more systematic, commonly recognised basic standards about the services that people diagnosable with PDs should be able to access, whether these are provided through mainstream mental health services or dedicated services.

For both commissioners and mental health trusts, it is important that the comprehensive range of responses that apply to mental health problems is seen to apply equally to PD. In those areas where there are no dedicated PD services, then the bottom-line expectations regarding response to people diagnosable with PDs will be met through mainstream services and commissioners and trusts need to take any action necessary.

In this context, it may be helpful to use a version of the NSF standards as a reminder:

<b>Table 4: Standards for people diagnosable with personality disorders</b>	
<b>NSF Standard 1</b>	Mental health promotion – understanding of the potential impact of programmes for healthy neighbourhoods, communities and families on the development of PD; appropriate planning forums (eg LSPs), engaged and aware of PD perspectives; PD addressed in programmes to reduce stigma and discrimination
<b>NSF Standard 2</b>	Within primary care services, identification, assessment and management (with support) of less severe and disabling PDs, and referral on to specialist services where appropriate; jointly developed protocols for the management and treatment of PD across primary/secondary care
<b>NSF Standard 3</b>	Access to information and advice for people diagnosable with personality disorders  Contact with relevant services round the clock and access to services in crisis, which are appropriate
<b>NSF Standard 4 and 5</b>	Effective services for people with more serious/complex PDs: engagement; crisis management; Care Programme Approach or other care planning/coordination as appropriate; appropriate residential treatment/care if necessary; effective participation of service users
<b>NSF Standard 6</b>	Advice, information, support for carers of people diagnosable with PDs
<b>NSF Standard 7</b>	Preventing suicide in people diagnosable with PDs; ensuring staff are appropriately trained and aware; appropriate support to A&E departments to facilitate response to PD

## **Tier 2 – Community-based, PD-dedicated treatment and case management services**

In addition to the national pilots, a number of services are identified in plans which are either dedicated PD services, or likely to have high use by people diagnosable with PDs. It should also be noted that several trusts had indicated to commissioners that new services were in the process of planning or development. Much of the drive for development appears to be coming from psychological therapy services themselves, although some trusts had noted appointing PD leads to provide a management focus for development.

Services identified include:

- Dorset and Somerset – primary care psychological therapies for DSM Axis I (clinical syndromes); intensive psychotherapeutic service for DSM Axis II (personality disorders); DBT teams working with two CMHTs and rehabilitation service; DBT team for borderline PD in development; and access to mainstream cognitive behavioural (CBT), cognitive analytic (CAT) and other therapies;
- Kent, Surrey and Sussex – joint therapy service pilot DBT group;
- North West – Gaskells House and McCartney House, dedicated PD programme within psychotherapy service; Complex Care Team in Bury (which includes PD) and DBT skills group in Burnley;
- West Midlands – Walsall DBT skills training service and DBT services in North Worcestershire and Worcestershire, and access to mainstream psychotherapy services.

Some of these developments are quite small and are probably being driven by keen individual practitioners. Experience from the national programme has indicated that such small-scale developments need support.

It is also clear that, in many parts of the country, psychological therapy services are being reorganised to coordinate better with community mental health services and it is important that PD service provision remains on the agenda through such redesign initiatives. There is also a major policy review of psychological therapies under way within DH and linked to key trust sites. We suggest, therefore, that a workshop event bringing together some of the national pilots which have relevant experience, other people developing services and linking to the DH policy review might be valuable to all.

### **Tier 2 – Access to any PD-specific community criminal justice system services (services for offenders with PDs)**

No information on current services reported.

### **Tier 2 – Access to mainstream National Offender Management Service (services for offenders)**

On the whole, very little service provision is noted under this heading. A few plans report numbers of people diagnosable with PDs using probation hostels or known to Multi-Agency Public Protection Agreements (MAPPAs). These are helpful suggestions for further work that needs to be undertaken on a more comprehensive basis.

### **Tier 1 – The wider service network**

On the whole, little information was reported under this heading although the London plan identifies a number of voluntary sector services.

From the plans and from the experience of the national pilots, it is clear that voluntary sector agencies have a potentially important role to play across quite a wide range of service provision.

### **3.2 Identified gaps in current services**

There were a number of comments concerning gaps in provision and factors that limit current services and commissioning. For the most part, there are few surprises, and comments illustrate and document the patterns noted in *Personality disorder: No longer a diagnosis of exclusion*.

General comments about service gaps for people diagnosable with PDs, included:

- continuing difficulties because of inconsistent diagnosis and coding of PD;
- fragmented and poorly coordinated services;
- inadequate therapeutic resources to support recovery approaches;
- significant lack of skilled and experienced workers;
- need for change in attitude and approach by health and social care professionals;
- significant training and development needs across mainstream services;
- significant need for robust, coherent service and treatment models, and care pathways;
- significant need for better partnership working between agencies;
- need to improve the commissioning arrangements for PD services;
- lack of PD services for women;
- lack of PD services for BME communities.

### **Tier 5 – Secure and forensic PD services – dedicated PD treatment units/ programmes within secure services and associated community services**

There were several comments, including:

- There are no services as yet developed (beyond the few national forensic pilot schemes) for 'step down' following discharge from dedicated DSPD services.

- There are few/no dedicated PD units/programmes within medium-secure units in most areas.
- Some medium-secure units exclude people diagnosable with PDs.
- Some low-secure units exclude people diagnosable with PDs.
- The secure services workforce needs improved skills and attitudes.
- There is a need to improve movement/pathways between secure and other mental health services.
- Significant numbers of people diagnosable with PDs cannot be managed in local services and are placed in expensive out-of-area treatments.
- Forensic services available to people diagnosable with PDs tend to be fragmented and poorly coordinated.

#### **Tier 4 – Specialised inpatient and intensive services for those whose problems cannot be managed locally**

Generally, there were few comments about the need for the services provided by Henderson Hospital, Main House and Therapeutic Community Services North. On the whole, it appears that commissioners are holding a watching brief for the next one to three years of ‘steady state’ commissioning of these services, with a view to developing a better understanding of future need.

There were a few comments on the need for specialised inpatient care on a local, rather than on a geographically distant basis. The learning from the community PD pilots indicates that as PD-specific community services develop they are likely to uncover previously hidden need for such services.

#### **Tier 3 – More intensive day services, with treatment, case management and crisis support**

The majority of plans noted that such services are not currently available for people diagnosable with PDs in most, or all, of their geographical area.

**Of the mainstream mental health services** that may be available to people diagnosable with PDs in urgent, acute or serious need, the following comments were made:

- Many mental health inpatient services cannot cope with patients with PDs, and there is little agreement on effective treatment programmes for people diagnosable with PDs on acute wards.

- As a result, there are significant numbers of people diagnosable with PDs in out-of-area treatment.
- There is a need for specialist expertise in inpatient units in caring for people diagnosable with PDs.
- There is an absence of alternatives to hospital admission.
- Most but not all crisis resolution services are dealing with people diagnosable with PDs. However, for the most part, once the crisis is resolved, there is no ongoing service for people to be referred on to.
- There is a lack of agreed local guidelines for intervention in crises.
- Some psychiatric liaison services report that people diagnosable with PDs coming through A&E services and at high risk cannot be followed up as they are excluded from mental health services.
- The learning from the community PD pilots indicates that as such services develop they are likely to uncover previously hidden need for such acute or urgent-response services.

## **Tier 2 – Community-based treatment programmes for people diagnosable with PDs, crisis support and case management**

Generally, progress in developing ‘hub and spoke’ models for PD is limited.

## **Tier 1 – Focused support to the wider service network**

**Of the mainstream mental health services** that may be available to provide community-based treatment, case management and crisis support, the following comments were made:

- Some but not all assertive outreach services actively provide for people diagnosable with PDs.
- Some but not all early intervention services provide for people diagnosable with PDs.
- Access to community mental health services varies considerably; some exclude people diagnosable with PDs.
- Many psychological therapy services either exclude people diagnosable with PDs, or are organised in ways that effectively make access by people diagnosable with PDs difficult (ie complicated referrals, multiple assessments, long waiting lists etc).
- There is an absence of assertive models of engagement that can be delivered in the community.

**Of the mainstream criminal justice/offenders services** that may be available in the community for people diagnosable with PDs, the following comments were made:

- Probation services may have difficulties in accessing psychological assessment and management advice regarding people diagnosable with PDs.
- There is a lack of specialist mental health service support to approved premises in relation to people diagnosable with PDs.
- Joint work with MAPPAs needs further development as mental health service input is underdeveloped.

### Accommodation/housing

There were a number of comments indicating need for further development of accommodation/housing services, including:

- a range of appropriate accommodation;
- 'more tolerant' accommodation for both men and women with PDs and a forensic background is required.

### Primary care

While most plans did not have enough information from which to assess the strengths and weaknesses of responses to PD in primary care, there were some comments about primary care services managing people diagnosable with PDs and quite serious problems. Where there are no dedicated PD services, and mental health services are operating exclusion criteria, there may be strong pressure on primary care.

## Action recommended

Action is recommended to:

- support local commissioners and mental health trusts to ensure that people diagnosable with PDs can access services appropriate to need at medium, low and PICU levels of security;
- ensure that the use of mainstream secure mental health services by people with PDs is adequately reflected in local activity monitoring;
- undertake further systematic analysis of out-of-area placements for people diagnosable with PDs;
- provide consistent information on the use of secure services by people diagnosable with PDs (within standard frameworks to be developed by the National PD Development Team);
- ensure that specialist and local commissioners are provided with regular information on the development and learning from the forensic community PD pilots;
- coordinate a brief piece of scoping work on potential residential service models for further consideration by capacity planning groups;
- ensure that the implementation of psychological therapy policy adequately reflects the needs of people diagnosable with PDs, and PD-specific service development;
- coordinate a workshop event on development of PD-specific psychological therapy services.

# 4. Service models and treatments/interventions

It is important to consider the conceptual service models and treatment approaches that underpin the capacity plans. For the most part, these are as yet sketchy and will develop further in future. A summary of information from individual plans is provided at Appendix 3.

## 4.1 Treatment philosophy, approach and values

Not all plans make explicit statements about treatment philosophy and underlying values. The common themes through such statements are:

- promoting a recovery model;
- person-centredness, ie meaningful service user involvement in treatment processes and all aspects of service development;
- reducing the considerable stigma associated with the ‘personality disorder’ label;
- working across sectors, agencies and professional boundaries to incorporate a wide range of ideas and models – not just a purely ‘NHS’ or ‘mental health’ mindset;
- promoting attachment, engagement and consistency;
- developing understanding of what lies behind behaviour;
- recognising the need for long-term treatment and care planning.

## 4.2 Service models

In Appendix 3, service models have been divided into ‘community’ and ‘secure’; this reflects the general lack of integration between these service areas in the capacity plans, apart from a few small-scale, specific initiatives. The Tier 4, 5 and 6 provisions and plans are mostly for numbers of beds in units with specific qualities and standards; these are more commonly mainstream than PD-specific. The community and non-residential service plans demonstrate a much greater diversity of provision and intention. A minority of these express preference for mainstream services.

The commonest PD-specific service models are ‘hub and spoke’ and ‘managed network’. The hub and spoke model is typically proposed for non-metropolitan areas, covering a county or part of a county – with catchment and populations between a quarter and three-quarters of a million – with one central hub and several spokes. The nature of the hub is

generally a clinical team base, usually with a more intensive day unit treatment programme. The spokes vary more, and include opportunities for liaison, joint working and specific clinical services.

The managed networks more commonly involve a wider range of partner agencies from various sectors, and are more concerned with coordination of care than delivery of specific services or therapies. They typically arise from a process of gathering interested parties together to instigate the planning, and are more commonly proposed in large cities.

Some of the plans have prominent elements of both models, and most consider the necessary links with other existing and developing services. The relevance of capacity building and workforce development is frequently linked to the service models, as setting up such services has considerable implications, such as the need for suitably trained staff in numbers that may not exist locally.

Some areas made mention of small services (such as a team of two or three clinicians running a part-time DBT clinic). Little acknowledgement was made of the need for supervision, continuing professional development and management to support appropriate clinical governance; such arrangements are necessary to prevent them being 'drops in the ocean' liable to be vulnerable, or to become professionally isolated. However, several plans did stress the requirement for a high level of specialist training and expertise in psychotherapy.

### 4.3 Treatment approaches

The majority mention the specific treatments given as examples in the 2002 policy guide:

- dynamic psychotherapy;
- dialectical behaviour therapy (DBT);
- cognitive behavioural therapy (CBT);
- Therapeutic Community (TC);
- cognitive analytic therapy (CAT).

Other specific treatments being used or planned are group therapy, individual psychoanalytic therapy, systemic family therapy (SFT), expressive and creative therapies, humanistic and integrative therapy (HIP), art therapy and eye movement desensitisation and reprocessing (EMDR).

Establishment of self-help networks, at least for Tiers 1 and 2, were mentioned by some; others specified therapeutic needs in terms such as programmes for 'therapeutic engagement', rather than single theoretical approaches.

Several plans gave no indication about specific approaches for the clinical work, and it was often unclear what constituted a therapeutic intervention.

### Action recommended

Action is recommended to:

- ensure that commissioners, trust senior managers and other key postholders develop appropriate understanding of PDs and complex treatment approaches.

# 5. Workforce issues

## 5.1 Service development and workforce implications

Implementation of the development proposals set out in the capacity plans requires a PD-aware workforce.

All of the plans acknowledge this fundamental fact and most provide outline proposals for the development of a career/skills escalator, linked to the PD Capabilities Framework, to enable this development.

These proposals are, in a number of cases, underpinned by the training and learning developments that have been set in train in each of the NIMHE regions through the funds invested from the National PD Development Programme. These developments therefore provide a firm foundation for developing the workforce of the future. This potential will be enhanced if proposals to develop a web-based delivery system – the Learning Zone in the new national PD website accredited training programmes at various levels, including the South London e-learning package – are fully funded. These developments will enable large numbers of staff to access quality-assured and/or accredited training and learning opportunities to support capacity building, although it is acknowledged that e-learning is not, in itself, a total solution to training challenges.

A number of challenges are also identified. These include:

- Local partnerships with WDDs and departments are underdeveloped and there appears to be little interest in PD training or workforce development by either WDDs or Deaneries. Hence, there has been no commitment at local or regional level to sustaining existing training programmes after March 2006 and no assurance of future central funding.
- As a result, there is serious risk to all of the programmes commissioned by the National PD Development Team after March 2006.
- It is vital to develop national standards to ensure that training and learning opportunities in PD are of a high quality and can underpin the development of valued career pathways in PD.
- There are numerous gaps in the range of training and learning opportunities currently available. These do not yet address the needs of staff working at all six tiers of service, and cannot ensure that patients' pathways are properly supported, as described in the PD Capabilities Framework. There are, in addition, specific gaps in relation to

work with people with co-morbid PDs and learning difficulties for cross-cultural, anti-discriminatory practice in PD services; to address self-harming behaviours; to address issues of gender and sexuality; and to respond to the needs of carers.

In addition, the ‘emergent’ nature of proposals in many of the plans means that it is difficult at this stage to project future numbers of staff required to support a ‘whole systems’ approach to working with people diagnosable with PDs and in particular to estimate the numbers of staff which may be required at all six tiers. Further analytical work must be undertaken at national and regional levels to develop robust models for the future which include a description of the future workforce, including roles, ways of working, skills and an estimation of numbers. This is particularly required in relation to the proposals in some plans for fully integrated services at Tiers 3 to 6, where it is unclear how the distinct needs of those with PD (as opposed to psychosis) will be addressed.

Table 6 provides a summary of the workforce proposals from each of the plans. Most plans have not costed their workforce proposals. Therefore, future investment required has been estimated (in Table 6) by reference to benchmarks provided in Table 5. Table 5 provides an estimation of costs using best current benchmarks for training and workforce development for the period 2006–09. These costs are estimated per NIMHE region. A rationale for this is provided here (see page 46).

<b>Escalator tier</b>	<b>Target audience</b>	<b>Estimated deliverables</b>	<b>Estimated costs</b>
Awareness	Generic, non-specialist staff in all sectors and agencies	300 people per year accessing one and two-day courses via e-Kit platform/South London e-learning package and direct delivery approaches	£20,000 per year
Basic skills/ attitude development	Staff working directly with people diagnosable with PDs in all sectors and agencies	300 people per year accessing modules at level/s congruent with NVQ in care 2–4, utilising e-Kit platform/South London e-learning package and direct delivery approaches	£20,000 per year
Specialist clinical skills development/ continuous professional development	Specialist staff in NHS and criminal justice agencies  Students undergoing pre-registration training	100 staff accessing modules at level/s congruent with certificate/ diploma utilising e-Kit platform/ and direct delivery, on site and laboratory approaches  Developing and embedding PD relevance modules within existing curricula	£40,000 per year  £30,000 (one year only)

Table 5 (continued)			
Management and leadership and commissioning	Relevant managers and leaders in NHS and criminal justice sectors, including clinical leaders	40 staff accessing learning sets and networks in region/nationally to develop managerial and leadership skills	£40,000
		20 staff per year to access 'bolt on' modules for commissioners utilising 'blended learning approaches', accessing e-Kit modules and learning sets	£10,000
Developing service user/s and carers	Service users who are on a recovery pathway and carers to deliver 'train the trainers' courses etc	Up to 25 people per year to access 'blended learning approaches' to develop skills to include modules delivered via e-Kit (accredited to NVQ levels 2–4) and learning networks	£20,000
<b>Total</b> per region (recurring)			£150,000 per year (2006–09)
<b>Total</b> per region (non-recurring)			£30,000 (2006/07)

This indicated annual investment of £1.2 million for three years, totalling £3.6 million.

## 5.2 Rationale for estimating costs

Reference costs in this area are very difficult to establish. The estimates below are based on the best available information from the National Development Programme training and workforce initiative (North West, South East, East and South West regions) and the bespoke training developed for the forensic pilots and the Community Risk Assessment and Case Management Service (CRACMS) (in the North West) initiative. They are furthermore predicated on the full development of the proposed e-Kit and the South London e-learning package and securing the future, in the short term, of a number of the training programmes that have been commissioned through the National Development Programme. Unless these developments are protected and extended after March 2006, there will be a net loss of capacity for workforce development at this critical stage in the evolution of PD services nationally – and this will inevitably set back the aspirations of the local capacity plans. Hence, additional costs are identified to secure these developments and enable their full development in a number of regions.

Future developments must take place within a national initiative to establish a career/skills escalator for PDs, as set out in the PD Capabilities Framework.

While the estimated costs include an element to ensure the further development of the e-Kit and the South London e-learning programme, these will need to be supplemented by a capacity to directly deliver training, particularly in sectors where access to IT is limited (eg prisons) and in agencies where it is difficult to release staff for training. Future regional and local developments will need to take account of innovative methods of supporting skill development including on-site training, skills laboratories, whole team training, case problem discussion groups and team supervision.

For the purposes of this exercise, a crude attempt has been made to adjust funding requirements to reflect variations in the size and nature of the population living within each NIMHE region. In the future, a formula must be found to ensure that these regional variations in factors such as density of population, levels of deprivation, prevalence of PD and specific requirements for a workforce at all six tiers of service, are fairly taken into account in funding arrangements.

The NIMHE regions have been selected as the denominator for these costings for a number of reasons, as follows:

- The goal of developing a flexible workforce capable of working at all six tiers of service, within the framework of a skills escalator for PD is best undertaken at regional level, particularly in areas where the potential workforce supply may be limited.
- The development of a skills escalator approach, underpinned by national standards is likely to require a regional rather than a local focus.
- NIMHE RDCs have begun to develop their expertise in commissioning and supporting training and workforce developments, with support from the National PD Development Team. Regional steering groups and partnerships are already in existence in all regions, and some regions have undertaken recent training needs analysis, data from which have informed the capacity plans.
- Allocation of funding for training and workforce development to NIMHE regions may provide some protection for PD training budgets in a context of reconfiguration of WDDs and SHAs.

Table 6: Estimated total of financial investment required for workforce development for each region			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
Dorset and Somerset	<p>Aspirations include building capacity of primary care, clarifying roles of existing staff including Gateway workers, primary care graduates, support, time and recovery workers, counsellors etc</p> <p>Serious capacity problems in CMHTs may need to be resolved by reconfiguration but no extant proposals as yet</p> <p>Impacts through the system will occur from increasing capacity at Tiers 1–2. Trusts are considering how to extend crisis/24-hour services to people diagnosable with PDs in the context of capacity problems. Major reconfigurations and development of service models required but no detailed plans brought forward as yet</p> <p>Proposals for future training based on sustaining and extending training commissioned through the National Development Programme</p> <p>South West NIMHE PD leads rolling out a training package to all three trusts. Relationship of this to e-Kit to be clarified</p> <p>Urgent need for investments from WDDs etc to secure the sustainability of investments to date</p> <p>Numbers and roles of staff required in future at various tiers to be estimated</p>	<p><b>Somerset Partnership Trust</b></p> <p>Six tiers of training to be developed over short to long term (timescale unspecified)</p> <p>Tiers 4–6 linked to psychological therapy training (CAT and full psychotherapy training at Tier 5) plus supervising training</p>	<p><b>South West RDC</b></p> <p>Recurrent: £150,000</p> <p>Service user involvement: £20,000</p> <p>Non-recurrent: £30,000</p>
		<p><b>Dorset Healthcare</b></p> <p>Plan is to support a 'wider reaching' approach to the development of staff competency from basic awareness to formal psychotherapy training, delivered in multi-agency, team-focused manner</p> <p>Three levels of training to be provided in future. Level 3 in psychological interventions</p> <p>Joint working with higher education institutions</p> <p>Plans to develop a CD-ROM</p>	
		<p><b>North Dorset PCT</b></p> <p>Training on PD currently embedded in a range of specific and non-specific training</p> <p>Future plan is to base PD training on three levels as above: basic awareness, whole team training and specific interventions</p>	

Table 6 (continued)			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
Northern Forensic Catchment Group	<p>Little data on workforce to support the plan. Not broken down by tier. Only one organisation locally has a project lead tasked with developing pathways for PD, and huge differences within trusts</p> <p>Big training gaps with most capacity within departments of psychological therapies. Very little available for generic teams and no training plans in place in mainstream services</p> <p>Urgent action needed to develop training capacity</p> <p>Early thinking on developing managed clinical networks/stepped approaches in care for PD within the catchment area</p> <p>Workforce roles and numbers to be estimated</p>		See figures below for North West RDC
South Catchment Group	<p>Focus on secure services only (Tiers 4–6)</p> <p>Focus on bed capacity and utilisation rates in men's, women's and learning disability services, ie on need</p> <p>No specific consideration of workforce numbers/roles or skills although there is implicit recognition of the need to develop the skills of staff to work with special needs, including learning disabilities, and to manage 'flow through and step down' of care, and develop specialised commissioning skills</p>		See figures above for South West RDC
Thames Valley and Swindon	Fully costed proposals put forward for developing future capacity based on principles of equity, mainstreaming funding, addressing pathways, valuing the voluntary sector and prioritising training. Costs of preferred option (2), which would see all areas within the region 'levelled up' to 'enhanced Oxford level' does not include 'whole systems' workforce requirements and training		<p><b>South East RDC</b></p> <p>Recurrent: £150,000</p> <p>Service user involvement: £20,000</p> <p>Non-recurrent: £30,000</p>

Table 6 (continued)			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
Avon, Gloucestershire and Wiltshire and West of England LSCG	<p>Workforce considerations are addressed with developed proposals for service in all countries (all with locality focus) at Tiers 1 to 4</p> <p>Further workforce detail required in relation to Tiers 4–6</p> <p>Skills and capacity development to take place within an agreed multi-agency practice development framework</p> <p>Staff numbers quantified in relation to several of the proposed new service developments but no estimation as yet of numbers likely to require training/ skills development in non-NHS, mainstream services</p>	<p><b>Avon model</b></p> <p><i>Tiers 1–2</i></p> <p>Two levels of training to be developed, basic for non-specialist front-line staff and intermediate course for specialists and others</p> <p>Training in specialist telephone support to link to early intervention work with young people</p> <p><i>Tiers 2–3</i></p> <p>Establishment of Avon Specialist PD Team – network of skilled individuals to provide community-based psychological therapy and case management in four localities</p> <p>Service user-led training to be provided for inpatient support</p> <p>Crisis units</p> <p>Increase access to specific psychosocial intervention training</p> <p>Increased supervisory expertise</p> <p>Development of mentalisation-based therapy (MBT)</p> <p><i>Tier 3</i></p> <p>Establishment of specialist day service</p> <p>Training as with Tier 2, with emphasis on MBT</p>	See figures above for South West RDC

Table 6 (continued)			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
		<p><b>Wiltshire model</b></p> <p><i>Tier 1</i></p> <p>Further support and development to wider system, workforce needs not explicitly addressed</p> <p><i>Tier 2</i></p> <p>Strengthening of local strategic coordination groups in three localities to provide further development of Tier 2 provision and better management of care pathways for people diagnosable with PDs, leading to 'virtual' specialist teams to provide direct care, consultation, training and supervision to Tiers 1 and 2</p> <p><i>Tier 3</i></p> <p>Plans developing for both urban and rural areas to provide intensive day treatment service (Swindon in 2005)</p> <p>Extended timescale in rural areas where focus will be on 'diverse portfolio of Tier 2 services'</p>	

Table 6 (continued)			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
		<p><b>Gloucestershire model</b></p> <p><i>Tier 1</i></p> <p>Building a practice network across the county</p> <p>Provision of training for existing staff to develop skills in case management and specific psychological therapies</p> <p>Link with existing modules at University of the West of England and Plymouth</p> <p>Link with early intervention work</p> <p>Promote user and carer engagement including development of 'expert patients'</p> <p><i>Tiers 2 and 3</i></p> <p>Development of holistic case managers with training and supervisory elements to their roles</p> <p><i>Tier 3</i></p> <p>Develop crisis response</p> <p>Offer day treatment to prevent revolving-door hospital admissions</p> <p><i>Tier 4</i></p> <p>No changes planned in short term. To be addressed after development of local services</p>	

Table 6 (continued)			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
		<p><i>Tiers 5 and 6</i></p> <p>Development of whole-system approach to include development of forensic PD teams to network with generic PD teams, substance misuse services, prison in-reach, MAPPAs, CAMHS etc</p> <p>Close operational integration with Tiers 1 to 4 required to support development of pathways approaches to care</p> <p>Likely requirements for additional medium-secure unit beds and post-DSPD provision (Tiers 5a and 6) by numbers not specified at this stage</p> <p>Therapeutic community wings to be developed in prison</p>	
Eastern	<p>Very comprehensive plan and action plan</p> <p>Workforce considerations are addressed throughout. Building capacity is heavily reliant in securing further funding to sustain and extend the range of training developments in place within the region through the National PD Development Programme and complementary initiatives by several trusts</p> <p>Securing this training and education capacity will underpin the formulation of a workforce development strategy for the East of England</p> <p>Links specified to e-Kit with consideration given to development of specialist modules to support proposed service developments at Tiers 4–6</p> <p>Service user involvement in shaping training. Delivery of training already evident and action plan proposals will extend this further</p>		<p><b>Eastern RDC</b></p> <p>Recurrent: £150,000</p> <p>Service user involvement: £20,000</p> <p>Non-recurrent: £30,000</p>

Table 6 (continued)			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
West Midlands	<p>Workforce development implications are considered in relation to the West Midlands Training Strategy for Personality Disorder, developed to support the disbursement of £250,000 provided through the National PD Development Programme</p> <p>Plan outlines a skills escalator for PD providing training and workforce development in the West Midlands to support capacity development at Tiers 1–6</p> <p>Range of approaches being considered to implement this plan involving partners from regional higher education institutions</p> <p>Potential for utilisation of the e-Kit</p> <p>No sustainability of funding from local partners as yet</p>		<p><b>West Midlands RDC</b></p> <p>Recurrent: £200,000</p> <p>Service user involvement: £20,000</p> <p>Non-recurrent: £30,000</p>
South West Peninsula	<p>Plan to deliver training at three levels – awareness, basic and specialist – linked to the Personality Disorder Capabilities Framework</p> <p>Also plans for training and education for new roles, including primary care mental health workers (no numbers)</p> <p>Support, time and recovery workers (no numbers) and associated mental health practitioners</p> <p>Review of training needs to take place to coincide with review of current provider contracts</p> <p>Joint commissioning with Dorset and Somerset of some training</p> <p>Commitment to addressing the training needs of service users and carers</p> <p>NIMHE South West training package to be utilised (see notes above)</p>		<p>See figures above for South West RDC</p>

Table 6 (continued)			
Source	Comments on workforce proposals	Training capacity	Future investment required 2006–09 within NIMHE region (adjusted for population covered)
East Midlands and South Yorkshire	<p>Skills development for general mental health staff a key gap in capacity</p> <p>Plan outlines are needed for the following:</p> <p>Services to undertake training needs assessment for all staff</p> <p>Roll-out of existing training (forte/landscaped project) commissioned through National PD Development Programme</p> <p>Proposals for service developments at Tier 1 and Tiers 4 to 6 not quantified in terms of staff number and training required</p>		<p><b>East Midlands RDC</b></p> <p>Recurrent: £200,000</p> <p>Service user involvement: £20,000</p> <p>Non-recurrent: £30,000</p>
Kent, Surrey and Sussex Secure Services Consortium	<p>The Consortium has commissioned work to develop a workforce strategy, as outlined in its commissioning strategy 2004–09</p> <p>Workforce strategy will take account of changing needs of users and new service models/new ways of working</p> <p>It will address needs of people at all levels</p> <p>It will outline number of staff required/new roles to fill gaps</p> <p>Too early to provide details. Costs will need to be estimated</p>		<p>See figures above for South East RDC</p>
Yorkshire	<p>Workforce considerations linked to implementing the NIMHE North East PD training plan in 2006</p> <p>No estimation of deliverables from this implementation</p> <p>No estimation of staff numbers/roles at Tiers 1–6 and consequent education and training likely to be required to implement the proposed service developments within region</p>		<p><b>North East RDC</b></p> <p>Recurrent: £200,000</p> <p>Service user involvement: £20,000</p> <p>Non-recurrent: £30,000</p>

<b>Table 6 (continued)</b>			
<b>Source</b>	<b>Comments on workforce proposals</b>	<b>Training capacity</b>	<b>Future investment required 2006–09 within NIMHE region (adjusted for population covered)</b>
London	Two-stage process in train to develop a PD capacity plan. Current plan is stage 1 – a high-level scoping of current need and evidence, including stakeholder views. It outlines a range of principles for future service, and hence workforce, development but only to argue the case for more in-depth work to scope capacity and to make a unified capacity plan for London from Tiers 1 to 6		<b>London RDC</b> Recurrent: £250,000 Service user involvement: £20,000 Non-recurrent: £60,000
North West	NW NIMHE is implementing a career skills escalator in line with the 10 ESC Gaps from this exercise are identified, as are target audiences at all levels and in all sectors Range of training initiatives commissioned via National Development Programme are being rolled out. e-Kit will enable dissemination to wider audiences to meet skills gaps Future developments must include access to training and education at all levels, linked to a proper skills escalator and tied to new ways of working, utilising new staff roles Current training developments not yet in receipt of sustainable funding		<b>North West RDC</b> Recurrent: £200,000 Service user involvement: £20,000 Non-recurrent: £50,000
National Programme – continued development plans (website Learning Zone)			£500,000
<b>TOTALS</b>			<b>Recurrent:                      £1,660,000</b> <b>Non-recurrent,                      to include costs                      of continued                      developments:                      £790,000</b>

## Action recommended

Further action is recommended to:

- develop a model for projecting future workforce needs (roles and numbers) at all six tiers of service provision;
- sustain existing regional training developments and work with local commissioners to ensure that there is appropriate training to address regional and local gaps and to support the development and implementation of care pathways across all six tiers of provision;
- develop guidelines on the capabilities required to work with people with co-morbid PDs and learning difficulties, and commission and disseminate a relevant training package based on these guidelines;
- develop guidelines for commissioners of education and training for PD;
- develop further guidance, linked to the 10 ESC, to underpin the future development of a national training and skills escalator for PD;
- develop guidance on new ways of working within services for people diagnosable with PDs and their carers;
- develop pathways into meaningful employment within PD or mainstream services for recovering service users and carers;
- develop protocols to underpin service user and carer involvement in training.

## 6. Service user and carer participation

A number of the plans acknowledge the need to develop the capacity of service users and carers to participate in the development of local and regional services and to contribute to the development of a PD-capable workforce. As with the workforce proposals, a number of the plans take into account the ways in which service users and carers have been involved within the National PD Development Programme and acknowledge the need to consolidate and extend these developments. Proposals by the National PD Development Team to ‘regionalise’ the service user and carer dimensions of the national programme will support these aspirations.

In building future capacity, it will be vital to ensure that service user and carer involvement is comprehensive and seen to be relevant and meaningful at all six tiers of service delivery. Most plans do not, as yet, develop proposals in this area in relation to Tiers 3–6. Future guidance from the centre may be helpful in this regard.

A minority of the plans acknowledge the role that service users and carers can play in developing the capability of the future workforce by their contributions to staff training and development. In a context in which the stigma currently associated with PD is a significant constraint in the recruitment and retention of staff, the expertise of service users who have recovered and of carers is a vital resource to draw upon in the development of a PD-capable workforce. Recovered service users and carers, working in new ways, may be key to the implementation of capacity plans in the future and provision must be made for supporting this development. Only one plan provided detailed proposals for the development of ‘treatment to work’ employment pathways for service users. By and large, the plans were not well developed in relation to the need to address the needs of carers. This reflects the lack of national policy attention to carers’ needs in the context of PD.

Costings of workforce proposals above identify a specific element for developing service users and carers to take on new roles.

### Action recommended

Action is recommended to:

- sustain and extend existing national and regional structures for user and carer participation;
- consider specifically the needs of carers of people diagnosable with PD and bring forward guidance on their requirements for services.

# 7. Development proposals and resource implications

## 7.1 General comments and development proposals

The capacity plans show wide variation in the development of strategic ideas and of progress towards definite proposals for development. This is not unexpected but indicates that there is a need for further clarification of key features of the appropriate range of PD services in future development of service and workforce development plans.

Information on development proposals in some areas are clearly articulated and accurately costed. In others there are, as yet, no specific service developments agreed and the progress with planning towards this objective varies widely.

In most cases, the service development focus is either specific local population centres or individual provider catchments. Developments based on a 'whole system' approach are widely aspired to but only a few plans indicate significant progress with this approach. The idea of a development plan that covers the needs of the total population at all levels is still, for most, some way off.

Rural and urban differences have been considered by some but often without as yet clear enough ideas on resolving tensions between geography, availability and complexity of provision.

As a consequence, most plans have identified further work to develop the right networks and investigate need. This is appropriate in that the practicality of bringing together partnerships and identifying leaders and expertise is not a short-term task. However, few of these additional actions are costed and most have no clearly identified timescales at this stage.

Overall, the development proposals can be said to show differences in understanding and level of attention so far paid to PD services. Some areas reflect considerable advance in planning for service development, while others have only begun to address key planning and clinical questions as a direct result of the capacity planning exercise. Where there are pilot sites up and running, we would expect perhaps a more developed level of thinking but this is not always the case. Except for a few established PD networks, there is a sense that the need for innovation and thinking 'out of the "health" box' is still to be achieved.

Generally, there is an awareness of the potential prison demand, and 'forensic' consideration has been addressed in all of the plans. However, there is still considerable blurring in the differentiation between mental illness and PD. This is compounded by some ambivalence

about health/social care/criminal justice responsibilities. The fact that a high/medium-secure capacity plan is being produced separately by each catchment group may yield more accurate development plans for this level of PD service provision, but may also have been a cause of confusion.

There are some interesting proposals to either redesign existing services or repatriate out-of-area placements to reinvest locally, and most plans have considered work on improving access to mainstream mental health services as a core aspect of improving PD provision.

Learning disabilities are raised in an unresolved debate about their relation to PD and challenging behaviour but no specific proposals for developments in this field are made.

Three plans consider the links between CAMHS, early intervention and emergent PD. However, issues relating to substance misuse and PD are not considered as much as might be expected. One unidentified area of need is that of men and women leaving military service. The concerns raised in the past by the Ministry of Defence have not appeared on the radar of current PD planning groups in spite of the responsibility for these individuals resting with their local PCT on discharge.

The overall feel is that there is some useful work in progress but, as yet, few areas have robust plans that are agreed by all the necessary stakeholders, and on which firm investment programmes can be based. Leadership and resources to develop the local and regional PD planning and service field are generally not clearly identified, yet it is hard to imagine progressing some quite interesting and optimistic plans without the leadership and time being quantified.

## 7.2 Service development proposals

Three elements of development have been identified in the analysis:

- proposed direct service developments;
- proposed organisational developments;
- other proposed actions.

Full details are provided in Appendix 4.

As the tiered approach has been variously interpreted, the following simplification has been used for the purpose of the analysis of development proposals:

**Tiers 5 and 6** – prison, secure and forensic services, including potential DSPD step down and community forensic teams, where it is indicated that the management of significant risk to others is a key element in case management and treatment.

**Tiers 3 and 4** – residential care, inpatient and intensive day care services, acute psychiatric and interim day treatment.

**Tiers 1 and 2** – community-based treatment with case management and access to crisis support. Also wider network support.

In each of the tiers, a range of service developments have been proposed although the descriptions do not always clearly locate the level of service proposed.

**Tiers 5 and 6:**

- inpatient assessment and treatment in medium and low-secure settings;
- secure PD services for women;
- step down and community forensic PD services;
- intensively supported accommodation for high and medium-secure step down;
- in-reach to prison and prison-based assessment and treatment services.

**Tiers 3 and 4:**

- inpatient and intensive day service assessment and treatment.

**Tiers 1 and 2:**

- PD-specific ‘hub and spoke’ community services with intensive care management;
- specialist multidisciplinary and ‘virtual’ PD teams;
- early intervention and crisis response services and specific treatment (eg DBT) teams;
- complex needs services;
- hostel/accommodation services;
- increased psychology and counselling in primary care;
- enhancements in substance misuse services;
- self-help and user-led initiatives;
- carer support services;
- PD early intervention services;
- a range of PD prevention programmes are indicated particularly for children and young families;
- specialist PD workers in primary care.

Review of out-of-area placements is proposed by a number of plans as a basis for maximising financial resources and redesigning services to provide more locally.

### 7.3 Organisational development proposals

These cover a wide range of organisational activities that are both aimed at generating new service developments or strengthening and improving capacity in, and access to, mainstream mental health services.

These proposals cover:

- agreeing local PD strategies and implementation plans;
- PD network and forum developments;
- review, redesign and reconfiguration of existing PD and mental health services;
- improvement in commissioning arrangements;
- development or strengthening of partnerships;
- formalising agreements and protocols;
- development of self-help initiatives;
- identification of PD leadership in trusts;
- developing and agreeing pathways of care;
- auditing existing provision for effectiveness;
- implementation of a 'whole systems' approach to service planning and delivery;
- strengthening links between forensic and non-forensic services and systems;
- reviewing access criteria for mental health services;
- making links into prisons and supporting prison discharge;
- establishing Experts by Experience programmes;
- active PD workforce planning;
- actions to retain the existing specialist PD workforce.

## 7.4 Other proposed action

Much of this work relates to completing the capacity planning process at this stage but also actions to establish PD in the mainstream of services and as relevant to a wider spectrum of public services, including:

- continue work on the wider debate and development of PD-related service areas to include learning disabilities, children and adolescents, older people and BME need;
- further needs assessment and gap analysis;
- establishment of an Axis II Institute;
- developing clearer evidence-based models of treatment;
- providing better support for PD service users and carers;
- improving voluntary sector links;
- creation of a single organisation for forensic psychological care;
- improving support to housing agencies;
- promoting service user evaluation;
- developing costed capacity and development plans;
- seeking to consider the expansion of successful existing PD services;
- better links to PD training initiatives;
- improvement in local data on PD;
- work with DSPD services to design and develop PD services;
- specification for prison in-reach to identify and respond to PD needs;
- planning for the sharing of skills;
- redesigning A&E responses to deliberate self-harm;
- considering NHS and private sector development options;
- considering the impact of DSPD and the Mental Health Bill on service demand locally.

## 7.5 Investment implications

Appendix 4 provides details of proposals with costs, where they are identified, from each of the capacity plans.

In order to support future planning, we have estimated resources required for proposals where costs have not been identified. A ‘broad-brush’ indication of required resources is provided below at Table 7.

Table 7: Broad-brush financial investment required, 2006–10				
Catchment	Area	Identified costs	Uncosted proposals	Estimated cost of all uncosted proposals at 2005/06 prices
Thames Valley	Thames Valley	£920,000	Regional PD development team	£150,000 for three years
Eastern	Eastern	£7.774 million	Costed plan	
North West	North West	NIL	PD development team	£150,000 for three years
West Midlands	West Midlands	NIL	New step-down services linked to medium-secure unit (five beds and community team)	£1.75 million
			Substance misuse and PD	£326,000
South West	South West Peninsula	£120,000	Prison PD in-reach	£500,000
			Women’s PD secure service	£2.3 million
			Medium-secure PD community service (five inpatient beds)	£1.3 million
			Community specialist teams (three)	£875,000
			Network development	£263,000
	Avon, Gloucestershire and Wiltshire	£1.828 million	Costed plan	
East Midlands and South Yorkshire	East Midlands and South Yorkshire	NIL	Women’s medium-secure PD service	£2.3 million
			Private sector PD service contract	Not costed
South East	Dorset and Somerset	£915,000	Costed plan	
	Hampshire and Isle of Wight	NIL	No development proposals	
Yorkshire	Yorkshire	£4.45 million	Costed plan	
Northern	Northern	£180,000	No development proposals	

Table 7 (continued)				
Catchment	Area	Identified costs	Uncosted proposals	Estimated cost of all uncosted proposals at 2005/06 prices
London	London	£1.033 million	Costed plan due October 2005	
Kent, Surrey and Sussex	Kent, Surrey and Sussex	NIL	No development proposals	
	Kent, Surrey and Sussex (forensic)	NIL	Not costed at this stage (see national secure capacity plan)	
Sub-total		£17,220,000		£9,914,000
<b>Total</b>				<b>£27,123,000</b>

## Action recommended

Action is recommended to:

- further develop current capacity plans into costed development proposals which:
  - appropriately engage stakeholder agencies;
  - reflect effective care pathways;
  - indicate effective interventions towards improved outcomes;
  - incorporate perspectives relating to substance misuse, anti-social behaviour and long-term social care management.

## Appendix 1 – Capacity plans, geographical coverage

Plan	SHA(s)	Specialised Commissioning	PCTs
Northern	County Durham & Tees Valley SHA Northumberland, Tyne & Wear SHA Cumbria & Lancashire SHA part	Northern SCG	Carlisle & District; Eden Valley; West Cumbria; Newcastle; North Tyneside; Hartlepool; North Tees; Durham Dales; Darlington; Derwentside; Durham & Chester-le-Street; Easington; Sedgfield; Gateshead; South Tyneside; Sunderland Teaching; Middlesbrough; Langbaourgh; Northumberland Care Trust
North West	Cheshire & Merseyside SHA Cumbria & Lancashire SHA (part) Greater Manchester SHA	North West SCG	Blackburn with Darwen; Morecambe Bay; Chorley & South Ribble; West Lancashire; Hyndburn & Ribble Valley; Burnley, Pendle & Rossendale; Preston; Fylde; Wyre; Blackpool; South Manchester; Central Manchester; North Manchester; Trafford South; Heywood & Middleton; Salford; Trafford North; Stockport; Ashton, Leigh & Wigan; Bolton; Oldham; Bury; Rochdale; Tameside & Glossop; Bebington & West Wirral; Southport & Formby; North Liverpool; Birkenhead & Wallasey; Cheshire West; Central Cheshire; Eastern Cheshire; Ellesmere Port & Neston; Central Liverpool; South Liverpool; Halton; Warrington; St Helens; Knowsley; South Sefton
Yorkshire	West Yorkshire SHA North & East Yorkshire & Northern Lincolnshire SHA	Yorkshire SCG	North East Lincolnshire; Selby & York; East Yorkshire; Yorkshire Wolds & Coast; Eastern Hull; Western Hull; North Lincolnshire; Hambleton & Richmondshire; Craven, Harrogate & Rural District; Scarborough, Whitby & Ryedale; Airedale; Bradford City Teaching; Bradford South & West; North Bradford; Eastern Wakefield; Wakefield West; Leeds West; Leeds North East; East Leeds; South Leeds; Leeds North West; Calderdale; North Kirklees; Huddersfield Central; South Huddersfield
East Midlands & South Yorkshire	South Yorkshire SHA Leicestershire, Northamptonshire & Rutland SHA Trent SHA	East Midlands & South Yorkshire SCG	Doncaster Central; Chesterfield; North Sheffield; North Eastern Derbyshire; Doncaster East; Doncaster West; Sheffield West; Sheffield South West; South East Sheffield; Bassetlaw; Rotherham; High Peak & Dales; Barnsley; Central Derby; Mansfield District; Newark & Sherwood; West Lincolnshire; Lincolnshire South West Teaching; Gedling; Amber Valley; Nottingham City; Erewash; Broxtowe & Hucknall; Greater Derby; Ashfield; Rushcliffe; Derbyshire Dales & South Derbyshire; East Lincolnshire; Daventry & South Northamptonshire; Melton, Rutland & Harborough; Leicester City West; Eastern Leicester; Hinckley & Bosworth; Charnwood & North West Leicestershire; South Leicestershire; Northamptonshire Heartlands; Northampton

Plan	SHA(s)	Specialised Commissioning	PCTs
West Midlands	Birmingham & The Black Country SHA West Midlands South SHA Shropshire & Staffordshire SHA	West Midlands SCG – Specialised Services Agency	Burntwood, Lichfield & Tamworth; Staffordshire Moorlands; Newcastle-under-Lyme; Shropshire County; North Stoke; South Stoke; Telford & Wrekin; East Staffordshire; Cannock Chase; South Western Staffordshire; Solihull; South Birmingham; Oldbury & Smethwick; Rowley Regis & Tipton; Wednesbury & West Bromwich; North Birmingham; Heart of Birmingham Teaching; Eastern Birmingham; Dudley South; Dudley Beacon & Castle; Walsall Teaching; Wolverhampton City; Herefordshire; Wyre Forest; Rugby; Coventry Teaching; North Warwickshire; South Warwickshire; Redditch & Bromsgrove; South Worcestershire
London	North East London SHA North West London SHA Central London SHA South East London SHA South West London SHA	London SCG	Hillingdon; Hammersmith & Fulham; Ealing; Hounslow; Brent Teaching; Harrow; Kensington & Chelsea; Westminster; Barnet; Enfield; Haringey Teaching; Camden; Islington; Havering; Barking & Dagenham; City & Hackney Teaching; Tower Hamlets; Newham; Redbridge; Waltham Forest; Bromley; Greenwich Teaching; Lambeth; Southwark; Lewisham; Kingston; Croydon; Wandsworth; Richmond & Twickenham; Sutton & Merton; Bexley Care Trust
Eastern	Norfolk, Suffolk & Cambridgeshire SHA Essex SHA Bedfordshire & Hertfordshire SHA	Eastern SCG	Norwich; North Peterborough; South Peterborough; West Norfolk; Southern Norfolk; Huntingdonshire; Great Yarmouth; Cambridge City; South Cambridgeshire; East Cambridgeshire & Fenland; Broadland; North Norfolk; Ipswich; Suffolk Coastal; Central Suffolk; Waveney; Suffolk West; Hertsmere; Luton; Bedford; Bedfordshire Heartlands; Welwyn Hatfield; North Hertfordshire & Stevenage; South East Hertfordshire; Royston, Buntingford & Bishop's Stortford; Watford & Three Rivers; Dacorum; St Albans & Harpenden; Tendring; Epping Forest; Southend; Harlow; Maldon & South Chelmsford; Colchester; Uttlesford; Billericay, Brentwood & Wickford; Thurrock; Basildon; Chelmsford; Castle Point & Rochford; Witham, Braintree & Halstead Care Trust
Kent, Surrey & Sussex	Kent & Medway SHA Surrey & Sussex SHA	Kent, Surrey & Sussex LSCG	Adur, Arun & Worthing; Bexhill & Rother; Brighton & Hove; Crawley; East Elmbridge & Mid-Surrey; East Surrey; Eastbourne Downs; Guildford & Waverley; Hastings & St Leonards; Horsham & Chantconbury; Mid-Sussex; North Surrey; Sussex Downs & Weald; Western Sussex; Surrey Heath & Woking; Ashford; Canterbury & Coastal; Dartford, Gravesham & Swanley; East Kent Coastal Teaching; Maidstone Weald; Medway Teaching; Shepway; South West Kent; Swale
Thames Valley	Thames Valley SHA	Thames Valley & Swindon LSCG (NB Swindon covered in Avon, Gloucestershire and Wiltshire Capacity Plan)	Bracknell Forest; Slough; Windsor, Ascot & Maidenhead; Newbury & Community; Reading; Wokingham; Chiltern & South Bucks; Vale of Aylesbury; Wycombe; Cherwell Vale; North East Oxfordshire; Oxford City; South East Oxfordshire; South West Oxfordshire; Milton Keynes

Plan	SHA(s)	Specialised Commissioning	PCTs
Avon, Gloucestershire & Wiltshire	Avon, Gloucestershire & Wiltshire SHA	Part of West of England LSCG with South Wiltshire PCT from Central South Coast LSCG and Swindon	Bath & North East Somerset; Bristol North; Bristol South & West; Cheltenham & Tewkesbury; Cotswold & Vale; Kennet & North Wiltshire; North Somerset; South Gloucestershire; West Gloucestershire; West Wiltshire; South Wiltshire; Swindon
Dorset & Somerset SHA	This plan is based on a single SHA and then broken down by trust catchment area	Part of West of England LSCG and part of Central South Coast LSCG	Somerset Coast; Mendip; South Somerset; Taunton Deane; Bournemouth Teaching; North Dorset; Poole; South & East Dorset; South West Dorset
Devon, Plymouth & Cornwall	This plan covers Devon, Plymouth and Cornwall and then subdivides by trust catchment area	South West Peninsula LSCG	Central Cornwall; East Devon; Exeter; Mid Devon; North & East Cornwall; North Devon; Plymouth Teaching; South Hams & West Devon; Torbay Care Trust; West of Cornwall; Teignbridge
South SCG Forensic	Kent & Medway SHA; Surrey & Sussex SHA; Hampshire & Isle of Wight SHA; Thames Valley SHA; Avon, Gloucestershire & Wiltshire SHA; Dorset & Somerset SHA; South West Peninsula SHA	South SCG	Same as above for Devon, Plymouth & Cornwall; Kent, Surrey & Sussex; Dorset & Somerset; Thames Valley & Swindon; and Avon, Gloucestershire & Wiltshire PLUS New Forest; North Hampshire; Isle of Wight; South Wiltshire; Mid-Hampshire; East Hampshire; Portsmouth City Teaching; Blackwater Valley & Hart; Southampton City; Western Sussex; Fareham & Gosport; Eastleigh & Test Valley South
South SCG Severe Personality Disorder	Kent & Medway SHA; Surrey & Sussex SHA; Hampshire & Isle of Wight SHA; Thames Valley SHA; Avon, Gloucestershire & Wiltshire SHA; Dorset & Somerset SHA; South West Peninsula SHA	South SCG	Same as above for Devon, Plymouth & Cornwall; Kent, Surrey & Sussex; Dorset & Somerset; Thames Valley & Swindon; and Avon, Gloucestershire & Wiltshire PLUS New Forest; North Hampshire; Isle of Wight; South Wiltshire; Mid-Hampshire; East Hampshire; Portsmouth City Teaching; Blackwater Valley & Hart; Southampton City; Western Sussex; Fareham & Gosport; Eastleigh & Test Valley South

## Appendix 2 – Current services, geographical mapping

Capacity Plan: Avon, Gloucestershire and Wiltshire				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Avon	Wiltshire	Gloucestershire	
DSPD – access to high-secure PD services				
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services				
Forensic – access to specialist hostels				
Forensic – access to community teams				
Prison services – access to PD-specific services	3 prisons across area			
Non-forensic – access to specialist inpatient services	Main House, Birmingham (national specialist service)			
Non-forensic – access to intensive day care services				
Access to PD-specific community health services/casework, etc				
Access to PD-specific community CJS services/casework, etc				

Capacity Plan: Avon, Gloucestershire and Wiltshire				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Avon	Wiltshire	Gloucestershire	
Access to mainstream health, mental health, and drug and alcohol services	190 PD service users identified using mental health services provided by Avon and Wiltshire Mental Health Partnership NHS Trust, 2001  In South Wiltshire localities, 136 PD service users identified on CMHTs' caseloads, 2002		In Bristol and South Gloucestershire, 94 individuals with borderline personality disorder identified using mental health services, 2005	
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

**Capacity Plan: Devon, Plymouth and Cornwall (South West Peninsula)**

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Cornwall	Plymouth	Devon	
DSPD – access to high-secure PD services				
DSPD – access to prison-based services				64 beds for people with PDs commissioned in private sector
Forensic – access to medium and low-secure PD services				
Forensic – access to specialist hostels				
Forensic – access to community teams	Forensic team (within medium-secure service) DBT service			
Prison services – access to PD-specific services				
Non-forensic – access to specialist inpatient services				
Non-forensic – access to intensive day care services				
Access to PD-specific community health services/casework, etc		Icebreaker – PD pilot service for young people		
Access to PD-specific community CJS services/casework, etc				
Access to mainstream health, mental health, and drug and alcohol services	Mental Health Forums – self-help groups Developing joint PD network	DBT service	Experts by Experience Extraordinary People Sexual abuse and DBT teams	All are mainstream mental health services but noted that these are accessible to people diagnosable with PDs
Access to mainstream NOMS services				

Capacity Plan: Devon, Plymouth and Cornwall (South West Peninsula)				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Cornwall	Plymouth	Devon	
Access to PD-specific, or mainstream, social care, housing, employment services				

Capacity Plan: Dorset and Somerset SHA (NB: covers Tiers 1–3 only) outline capacity plan for services for people with PDs

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Dorset Healthcare NHS Trust	North Dorset PCT	Somerset Partnership Health and Social Care Trust	
DSPD – access to high-secure PD services			PD development plan agreed, 2003	
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services				
Forensic – access to specialist hostels				
Forensic – access to community teams				
Prison services – access to PD-specific services	6 prisons across area. Dorset and Somerset Prisons Partnership – detailed development plans for prison health services in process			
Non-forensic – access to specialist inpatient services				
Non-forensic – access to intensive day care services			PD development plan agreed, 2003 3 days per week psychotherapeutic day service for borderline PD patients	

Capacity Plan: Dorset and Somerset SHA (NB: covers Tiers 1–3 only) outline capacity plan for services for people with PDs				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Dorset Healthcare NHS Trust	North Dorset PCT	Somerset Partnership Health and Social Care Trust	
Access to PD-specific community health services/casework, etc	Primary care psychological therapies for Axis I  Intensive psychotherapeutic service for Axis II  DBT Team joint with Richmond Fellowship working with 2 CMHTs  DBT Team within mental health rehabilitation service	Developing DBT Team for borderline PD	CBT CAT Family systemic therapy Group analytical psychotherapy	
Access to PD-specific community CJS services/casework, etc				
Access to mainstream health, mental health, and drug and alcohol services	All eligibility criteria across trusts inclusive of PD			
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

Capacity Plan: East Midlands and South Yorkshire Commissioning Team Capacity Planning for Personality Disorder Services

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	South Yorkshire SHA	Leicestershire, Northamptonshire, Rutland SHA	Trent SHA	
DSPD – access to high-secure PD services	Rampton Hospital high-secure care			04/05 5 admissions, 5 discharges as at Feb 05, 27 patients
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services	Arnold Lodge, Leicester, medium-secure men-only PD unit Wathwood Hospital, medium-secure unit Annesley House, medium-secure unit for women with mental illness and PDs Spot purchase independent sector medium-secure placements for people diagnosable with PDs			12 patients at Feb 05 2 PD patients at Feb 05 6 admissions, 3 discharges 04/05 9 PD patients in independent sector at Feb 05
Forensic – access to specialist hostels				
Forensic – access to community teams	Forensic outreach team for East Midlands (Arnold Lodge)			
Prison services – access to PD-specific services	18 prisons across area			
Non-forensic – access to specialist inpatient services	Main House, Birmingham (national specialist service) Francis Dixon Lodge, Leicester – residential therapeutic community			50 places
Non-forensic – access to intensive day care services			Nottingham Community PD Pilot	16 places
Access to PD-specific community health services/casework, etc			Nottingham Community PD Pilot	
Access to PD-specific community CJS services/casework, etc	Probation hostels – number of residents with PD 58	Probation hostels – number of residents with PD 21	Probation hostels – number of residents with PD 2	

Capacity Plan: East Midlands and South Yorkshire Commissioning Team Capacity Planning for Personality Disorder Services				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	South Yorkshire SHA	Leicestershire, Northamptonshire, Rutland SHA	Trent SHA	
Access to mainstream health, mental health, and drug and alcohol services	Access to CMHTs: people with PDs estimated 10–50% of caseloads			
	PD – 2003/04 – number and % of admissions (general and forensic): 80; 1.41%	PD – 2003/04 – number and % of admissions (general and forensic): 300; 5.36%	PD – 2003/04 – number and % of admissions (general and forensic): 480; 5.15%	
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

**Capacity Plan: Eastern Specialised Mental Health Commissioning Group Personality Disorder Services Framework**

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Norfolk, Suffolk and Cambridgeshire SHA	Bedfordshire and Hertfordshire SHA	Essex SHA	
DSPD – access to high-secure PD services	Rampton Hospital high-secure care			Of 30 patients from Eastern area, 23 have PDs as at May 05
DSPD – access to prison-based services	Whitemoor Prison DSPD Unit			92 places
Forensic – access to medium and low-secure PD services	Norvic Clinic Broadland Clinic Eric Shepard Unit (medium-secure, learning disabilities)	SHA uses Runwell and Three Bridges Unit, London	Runwell	52 patients in medium-secure statutory and independent sector at Nov 04  Medium-secure and low-secure provision – eligibility criteria often exclude PD
Forensic – access to specialist hostels				
Forensic – access to community teams				
Prison services – access to PD-specific services				
Non-forensic – access to specialist inpatient services	Henderson Hospital, London (national specialist service)			03/04 12 admissions
			The Haven, Colchester – residential crisis beds	
Non-forensic – access to intensive day care services		Shrodells Unit, Watford	The Haven, Colchester – PD pilot service	
Access to PD-specific community health services/casework, etc	Cambridge and Peterborough PD service pilot		The Haven, Colchester – PD pilot service	
Access to PD-specific community CJS services/casework, etc				

Capacity Plan: Eastern Specialised Mental Health Commissioning Group Personality Disorder Services Framework				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Norfolk, Suffolk and Cambridgeshire SHA	Bedfordshire and Hertfordshire SHA	Essex SHA	
Access to mainstream health, mental health, and drug and alcohol services				
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

Capacity Plan: Hampshire and Isle of Wight Personality Disorder Plan			
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector		Capacity (eg beds, service levels, historic/current usage etc), where given
	Hampshire	Isle of Wight	
DSPD – access to high-secure PD services			
DSPD – access to prison-based services			
Forensic – access to medium and low-secure PD services			
Forensic – access to specialist hostels			
Forensic – access to community teams			
Prison services – access to PD-specific services			
Non-forensic – access to specialist inpatient services	Henderson Hospital, London (national specialist service)		
Non-forensic – access to intensive day care services			
Access to PD-specific community health services/casework, etc			
Access to PD-specific community CJS services/casework, etc			
Access to mainstream health, mental health, and drug and alcohol services	<p>Hampshire Partnership NHS Trust – 9 new DBT teams in process of training</p> <p>Basingstoke – pilot service offering DBT and CBT for repeat self-harm</p>		
Access to mainstream NOMS services			

Capacity Plan: Hampshire and Isle of Wight Personality Disorder Plan			
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector		Capacity (eg beds, service levels, historic/current usage etc), where given
	Hampshire	Isle of Wight	
Access to PD-specific, or mainstream, social care, housing, employment services			

Capacity Plan: Kent, Surrey and Sussex			
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector		Capacity (eg beds, service levels, historic/current usage etc), where given
	Kent and Medway SHA	Surrey and Sussex SHA	
DSPD – access to high-secure PD services	Broadmoor DSPD		
DSPD – access to prison-based services			
Forensic – access to medium and low-secure PD services	Trevor Gibbens medium-secure unit Southview and Ashen Hill, medium-secure services		No dedicated PD provision 20 PD patients (of 86 beds capacity) at Sep 04
Forensic – access to specialist hostels			
Forensic – access to community teams	5 community forensic teams across area		
Prison services – access to PD-specific services	17 prisons across area		
Non-forensic – access to specialist inpatient services	Henderson Hospital, London (national specialist service) Cassel Hospital St Andrews DBT Unit		
Non-forensic – access to intensive day care services	Brenchley Centre, Kent		70 patients
Access to PD-specific community health services/casework, etc		Joint Therapy Service, Chertsey, pilot DBT group (Surrey and Borders Partnership NHS Trust)	5 patients at Sep 04
Access to PD-specific community CJS services/casework, etc			

Capacity Plan: Kent, Surrey and Sussex			
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector		Capacity (eg beds, service levels, historic/current usage etc), where given
	Kent and Medway SHA	Surrey and Sussex SHA	
Access to mainstream health, mental health, and drug and alcohol services		<p>East Surrey substance misuse service 'responds positively' to PD</p> <p>Estimated 16% of acute mental health beds used by people diagnosable with PDs</p>	
Access to mainstream NOMS services			
Access to PD-specific, or mainstream, social care, housing, employment services			

### Capacity Plan: London Personality Disorder Capacity Plan (North London)

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	North Central London SHA	North West London SHA	North East London SHA	
DSPD – access to high-secure PD services				
DSPD – access to prison-based services		Bicester Road DSPD pilot – men Paddock Centre, DSPD, opening summer 2005		10 beds 70 beds
Forensic – access to medium and low-secure PD services				
Forensic – access to specialist hostels				
Forensic – access to community teams				
Prison services – access to PD-specific services				
Non-forensic – access to specialist inpatient services	Henderson Hospital, London (national specialist service)			
	Cassel Hospital TC adults, young people and families			50 inpatients and linked provision of 30 outreach; 10 day service
Non-forensic – access to intensive day care services	Pine St Day Centre, TC, 20–25 clients Halliwick Hospital Day Unit, 20 places	Waterview Centre, North Day Hospital (45 places for PD)	The Junction, Homerton, day programme (20–25 clients)	

Capacity Plan: London Personality Disorder Capacity Plan (North London)				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	North Central London SHA	North West London SHA	North East London SHA	
Access to PD-specific community health services/casework, etc	Oscar Hill Service, 40 places  Tavistock Clinic, Fitzjohn Service – PD psychotherapy service		Dual Diagnosis Assessment and Response Team, Waltham Forest, PD pilot service  Psychoanalytical psychotherapy unit	
Access to PD-specific community CJS services/casework, etc	Enfield and Barnet – PD treated within mainstream mental health services	Hammersmith and Fulham – PD treated within mainstream mental health services		
Access to mainstream health, mental health, and drug and alcohol services				
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services		Philadelphia Association, North West London, residential community providing long-term rehabilitation for people with PDs	St Andrews Meadow and Floating Support Cygnet Housing – 2–3 places of supported housing for people diagnosable with PDs	

Capacity Plan: London Personality Disorder Capacity Plan (South London)			
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector		Capacity (eg beds, service levels, historic/current usage etc), where given
	South West London SHA	South East London SHA	
DSPD – access to high-secure PD services			
DSPD – access to prison-based services			
Forensic – access to medium and low-secure PD services			
Forensic – access to specialist hostels			
Forensic – access to community teams		Oxleas – outpatient therapies for offenders  South London and Maudsley – Forensic Intensive Psychological Treatment service  York Clinic 3-day programme	
Prison services – access to PD-specific services			
Non-forensic – access to specialist inpatient services	Henderson Hospital, London (national specialist service) Cassel Hospital TC – adults, young people and families Crisis Recovery Unit		
Non-forensic – access to intensive day care services		Cawley Centre, day therapeutic community	
Access to PD-specific community health services/casework, etc	Personal Adjustment Disorders Service – long-term service for parents, adolescents and young people, adults		
Access to PD-specific community CJS services/casework, etc		Psychotherapy Unit	
Access to mainstream health, mental health, and drug and alcohol services			
Access to mainstream NOMS services			

Capacity Plan: London Personality Disorder Capacity Plan (South London)			
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector		Capacity (eg beds, service levels, historic/current usage etc), where given
	South West London SHA	South East London SHA	
Access to PD-specific, or mainstream, social care, housing, employment services	Asclepion supported housing and TC	DH pilot residential service for personality disordered offenders, Lewisham (Oxleas/ Turning Point/Probation Service)  START Team outreach service for homeless people  St John's Villas, Brixton, residential community for people with mental health problems and PDs	

**Capacity Plan: North West Catchment Group Personality Disorder Capacity Plan**

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Cheshire and Merseyside SHA	Cumbria and Lancashire SHA	Greater Manchester SHA	
DSPD – access to high-secure PD services	Ashworth high-secure care – PD unit			77 beds
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services	Edenfield Centre medium-secure services, Manchester Guild Lodge, Preston Scott Clinic, St Helens 5 low-secure facilities – all exclude PD			24 patients with PD across medium-secure and low-secure at Dec 04 (total of 161 beds)  Plans to develop 5-bed PD unit for men at Edenfield
Forensic – access to specialist hostels				
Forensic – access to community teams		Lancashire and South Cumbria Forensic Team	Greater Manchester Forensic Team	13 PD patients identified
Prison services – access to PD-specific services	15 prisons across catchment area			
Non-forensic – access to specialist inpatient services	Independent sector placements			68 PD patients in placements at Dec 04; 3.8% of all placements
Non-forensic – access to intensive day care services	Rotunda, Liverpool Fifteen, Manchester Red House	Hineraut Therapeutic Community PD service pilot		
Access to PD-specific community health services/casework, etc	Dedicated programme within psychotherapy – Gaskells House and McCartney House	Complex Care Team, Bury (includes PD) DBT Skills Group, Burnley		
Access to PD-specific community CJS services/casework, etc	Liverpool, of MAPPA cases levels 2 and 3, 40% had PDs			

Capacity Plan: North West Catchment Group Personality Disorder Capacity Plan				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Cheshire and Merseyside SHA	Cumbria and Lancashire SHA	Greater Manchester SHA	
Access to mainstream health, mental health, and drug and alcohol services		Bury team analysis estimates that 30% of total CMHT caseload had complex needs including PD		
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

Capacity Plan: Northern Forensic Catchment Group, Outline Capacity Plan Personality Disorders

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	County Durham and Tees Valley SHA	Northumberland, Tyne and Wear SHA	Cumbria and Lancashire SHA	
DSPD – access to high-secure PD services				
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services		National PD pilot		For one PCT, 12 patients with PDs reported across medium-secure, low-secure and Forensic Community Team
Forensic – access to specialist hostels				
Forensic – access to community teams		National PD Pilot		
Prison services – access to PD-specific services				
Non-forensic – access to specialist inpatient services	Out-of-area placements			5 out-of-area placements reported by 3 PCTs for people diagnosable with PDs
Non-forensic – access to intensive day care services				
Access to PD-specific community health services/casework, etc				
Access to PD-specific community CJS services/casework, etc				
Access to mainstream health, mental health, and drug and alcohol services				For one PCT, CMHT caseloads show 8–10% of patients with PDs, 160 cases in total; and for Assertive Outreach Team 19%, 168 cases in total

Capacity Plan: Northern Forensic Catchment Group, Outline Capacity Plan Personality Disorders				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	County Durham and Tees Valley SHA	Northumberland, Tyne and Wear SHA	Cumbria and Lancashire SHA	
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

## Capacity Plan: Services for People with a Personality Disorder in Thames Valley SHA

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Berkshire	Oxfordshire and Buckinghamshire	Milton Keynes	
DSPD – access to high-secure PD services				
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services	Oxford Clinic		Marlborough House	Thames Valley-wide strategy for forensic services under development. Plans to increase low-secure services significantly. PD treatment and response to be integrated within mental health secure services
Forensic – access to specialist hostels				
Forensic – access to community teams				
Prison services – access to PD-specific services	6 men's prisons across area			
Non-forensic – access to specialist inpatient services	Henderson Hospital, London (national specialist service)			10 referrals out of 89 nationally 2001–03
	Main House			9 referrals out of 57 nationally 2001–03
Non-forensic – access to intensive day care services	Winterbourne House, Reading	Thames Valley Initiative pilot PD service		
Access to PD-specific community health services/casework, etc				
Access to PD-specific community CJS services/casework, etc				

Capacity Plan: Services for People with a Personality Disorder in Thames Valley SHA				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Berkshire	Oxfordshire and Buckinghamshire	Milton Keynes	
Access to mainstream health, mental health, and drug and alcohol services		Approx 250 people with PDs known to mental health services	Approx 100 people with PDs known to mental health services – 10% of all cases	Approx 4–5% of psychiatric admissions are of people with PDs
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

## Capacity Plan: West Midlands Personality Disorder Capacity Plan

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Birmingham and The Black Country SHA	Shropshire and Staffordshire SHA	West Midlands South SHA	
DSPD – access to high-secure PD services				
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services	Reaside Clinic Hatherton Centre Ardenleigh (medium-secure for women)			All medium-secure provision noted as having considerable skill in managing PDs
Forensic – access to specialist hostels				
Forensic – access to community teams				
Prison services – access to PD-specific services				
Non-forensic – access to specialist inpatient services	Main House, Birmingham (national specialist service) Out-of-area placements for people with PD – significant and estimated at cost of approx £10m per annum			2000–04 Birmingham and The Black Country – 271 referrals, 48 admissions  Shropshire and Staffordshire – 77 referrals, 14 admissions  West Midlands South – 81 referrals, 16 admissions
Non-forensic – access to intensive day care services			Coventry PD pilot service	12 places
Access to PD-specific community CJS services/casework, etc				

Capacity Plan: West Midlands Personality Disorder Capacity Plan				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	Birmingham and The Black Country SHA	Shropshire and Staffordshire SHA	West Midlands South SHA	
Access to mainstream health, mental health, and drug and alcohol services	Walsall DBT skills training service Wolverhampton integrated psychotherapy service	North Staffordshire psychotherapy service	North Warwickshire DBT service South Warwickshire psychotherapy service Worcestershire DBT service	Not dedicated PD services but noted as having high numbers of people diagnosable with PDs
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

## Capacity Plan: Yorkshire Personality Disorder Capacity Plan

Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	West Yorkshire SHA	North and East Yorkshire and Northern Lincolnshire SHA		
DSPD – access to high-secure PD services				
DSPD – access to prison-based services				
Forensic – access to medium and low-secure PD services	Stockton Hospital, York (Partnerships in Care) medium-secure unit; PD unit for men			16 beds
	Medium-secure unit independent sector providers; Sept 04, 43 PD patients	Medium-secure unit independent sector providers; Sept 04, 24 PD patients		
Forensic – access to specialist hostels				
Forensic – access to community teams				
Prison services – access to PD-specific services				
Non-forensic – access to specialist inpatient services	The Retreat York; independent, charitable agency. Inpatient DBT service for borderline PD			
Non-forensic – access to intensive day care services	Diverse Pathways – TC programme in partnership with TCS North, Touchstone, Leeds and statutory agencies			Day service 1 day per week
Access to PD-specific community health services/casework, etc	Leeds Mental Health Trust – managed clinical network, PD pilot			

Capacity Plan: Yorkshire Personality Disorder Capacity Plan				
Service area	Services identified: name, location, type or character (eg TC), statutory or voluntary sector			Capacity (eg beds, service levels, historic/current usage etc), where given
	West Yorkshire SHA	North and East Yorkshire and Northern Lincolnshire SHA		
Access to PD-specific community CJS services/casework, etc				
Access to mainstream health, mental health, and drug and alcohol services				
Access to mainstream NOMS services				
Access to PD-specific, or mainstream, social care, housing, employment services				

## Appendix 3 – Summary of service models, treatments/interventions

Dorset and Somerset	
<b>Treatment philosophy and approach</b>	Recovery model; service user role development; commitment to inter-agency working
<b>Specific treatments existing or planned</b>	Centre of expertise in DBT (Poole); also provision of group analytic psychotherapy, family systemic therapy, CAT, CBT, expressive and psychodynamic approaches
<b>Service model (community)</b>	Three hubs of expertise, in Somerset Partnership Trust, Dorset Healthcare Trust and North Dorset PCT, based on service redesign and new investment
<b>Service model (secure)</b>	Part of South Catchment Group
<b>Integration: secure and community</b>	

West Midlands	
<b>Treatment philosophy and approach</b>	
<b>Specific treatments existing or planned</b>	CBT, DBT, psychodynamic, therapeutic community
<b>Service model (community)</b>	
<b>Service model (secure)</b>	
<b>Integration: secure and community</b>	

Eastern	
<b>Treatment philosophy and approach</b>	Emphasis on education, 'upstream investment', multi-agency working and specialist teams
<b>Specific treatments existing or planned</b>	Individual and group psychotherapy
<b>Service model (community)</b>	Flexible hub and spoke model with day services and multi-agency partnerships and pathways, good geographical accessibility and comprehensive service user involvement in planning and evaluation
<b>Service model (secure)</b>	Separate non-specialist units
<b>Integration: secure and community</b>	

Devon, Plymouth and Cornwall SHA	
<b>Treatment philosophy and approach</b>	Destigmatising, anti-discriminatory, based on exercising rights and responsibilities as citizens. Available locally and early, seeing recovery as balance of coping and cure
<b>Specific treatments existing or planned</b>	CBT, CAT, psychodynamic therapy, family therapy, DBT, EMDR mainly offered by clinical psychological services in generic team; but 'lack of experienced therapists and training initiatives, capacity and resources'
<b>Service model (community)</b>	Currently, inadequate resources to support recovery. Need to develop coordinated range of cross-agency, holistic, multidisciplinary services and training with support from local users and specialist staff, by innovative redesign within limited resources
<b>Service model (secure)</b>	Part of South Catchment Group
<b>Integration: secure and community</b>	9 forensic community and outreach teams

North West	
<b>Treatment philosophy and approach</b>	Aims to understand behaviour, minimise stigma and promote recovery. Treatment may be required over a period of years
<b>Specific treatments existing or planned</b>	Therapeutic communities, DBT, CBT, CAT
<b>Service model (community)</b>	Delivery by specialised PD services across PCT areas and at trust level
<b>Service model (secure)</b>	
<b>Integration: secure and community</b>	Prison in-reach teams proposed for assessment and support of inmates with PDs. Need to clarify existing secure care pathways and step-down requirements. Propose to pilot new ways of integrating secure and community care, for example CRACMS, residential accommodation that does not exclude people diagnosable with PDs, and specialist forensic outreach services

Yorkshire	
<b>Treatment philosophy and approach</b>	
<b>Specific treatments existing or planned</b>	Therapeutic community, DBT
<b>Service model (community)</b>	Stepped care model, with liaison psychiatry model for prison in-reach
<b>Service model (secure)</b>	
<b>Integration: secure and community</b>	The need for a forensic early intervention outreach service, and a prison PD liaison project, are identified

Kent, Surrey, Sussex	
<b>Treatment philosophy and approach</b>	A person-centred approach that puts the service user at the heart of service delivery and development
<b>Specific treatments existing or planned</b>	DBT, therapeutic community
<b>Service model (community)</b>	A multidisciplinary and multi-agency network of services to develop and support the care pathways, and specialist day unit and community outreach facilities
<b>Service model (secure)</b>	Part of South Catchment Group
<b>Integration: secure and community</b>	Need for step-down facilities and care pathways within and through medium and low-secure services identified

London	
<b>Treatment philosophy and approach</b>	Assessment, engagement, consistency, constancy, inpatient support, risk management and skilled practitioner input
<b>Specific treatments existing or planned</b>	Psychoanalytic psychotherapy, therapeutic community, CAT, DBT, CBT
<b>Service model (community)</b>	Divergent roles and models will be encompassed. Comprehensive and seamlessly accessed services are required to support each individual in the lowest tier possible, with development priority given to voluntary partnerships, primary and community care. A whole system redesign for provision of mainstream and specialist services is required
<b>Service model (secure)</b>	
<b>Integration: secure and community</b>	'Forensic services are integrated with community resources'

East Midlands and South Yorkshire	
<b>Treatment philosophy and approach</b>	
<b>Specific treatments existing or planned</b>	Group therapies and CBT specified as stakeholder priorities
<b>Service model (community)</b>	Interface between non-PD mental health services; criminal justice system; wider network of social, housing and day support services; and the dedicated PD services. This implies a hub and spoke model between the specialist team ('hubs') and other teams who work with people diagnosable with PDs ('spokes')
<b>Service model (secure)</b>	
<b>Integration: secure and community</b>	Need for development of prison in-reach services highlighted

Thames Valley and Swindon	
<b>Treatment philosophy and approach</b>	Recovery model with disengagement
<b>Specific treatments existing or planned</b>	Assertive engagement at Tier 1; various individual and group psychotherapies at Tier 2; therapeutic community at Tier 3
<b>Service model (community)</b>	Development of hub and spokes, and four clinical tiers (engagement; local treatment; intensive treatment; recovery), in line with Thames Valley Initiative pilot project. Closely integrated with service user involved network training programme; 'sustaining and developing the training programme is key to capacity building across the system'
<b>Service model (secure)</b>	Part of South Catchment Group
<b>Integration: secure and community</b>	In Berkshire, prison in-reach teams specifically exclude PD and Youth Offender Institution discharges to homelessness

South Catchment Group	
Treatment philosophy and approach	
Specific treatments existing or planned	
Service model (community)	
Service model (secure)	'Whole system view across high, medium and low-secure services must be maintained'
Integration: secure and community	

Hampshire and Isle of Wight	
Treatment philosophy and approach	
Specific treatments existing or planned	DBT, CBT
Service model (community)	
Service model (secure)	
Integration: secure and community	

Northern Catchment Group	
<b>Treatment philosophy and approach</b>	Socially inclusive, service user participation, early intervention. Clinical focus on resilience, coping and recovery with the least intrusive and least stigmatising effective treatment applied first
<b>Specific treatments existing or planned</b>	Therapeutic community, DBT, CAT
<b>Service model (community)</b>	'Stepped care' between primary care and secure care, with 'fluid movement through the system'. Level of dysfunction rather than diagnosis will determine access
<b>Service model (secure)</b>	
<b>Integration: secure and community</b>	'Specialist tertiary services including forensic services' as highest tier of model

Avon, Gloucestershire and Wiltshire	
<b>Treatment philosophy and approach</b>	Relationship and 'internal sense of security' focus. Recovery and social inclusion outcomes
<b>Specific treatments existing or planned</b>	CAT, DBT, group analytic therapy and psychodynamic psychotherapy. Also specific 'Therapeutic Engagement' work
<b>Service model (community)</b>	Network of specialist services with early intervention, equity of access and service user choice; integrated across health, other statutory, and non-statutory services including support, consultation and training. It will have an encompassing 'core of expertise', three specialist hubs and robust service evaluation in collaboration with local universities

## Appendix 4 – Financial investments proposed

Catchment	Thames Valley			Identified/Estimated (E) Cost	
	SHA/LSCG	Berkshire	Oxford and Bucks	Milton Keynes	
Proposed service development	Increase low-secure beds			Tiers 5 and 6	
	Pre-discharge and open community services				
	Hostel provision				
	Single centralised medium-secure unit				
Proposed service development	Single centralised women's specialised unit			Tier 4	
	Decentralised low-secure provision				
	Decentralised pre-discharge provision				
Proposed service development		Bucks 3-day TC	Revolving Doors initiative £70,000	Tiers 2 and 3	£70,000
			Specialist hub £200,000		£200,000
					Total for option 2 (all areas levelled up to provision comparable to enhanced Oxford model £920,000)
Proposed service development		Oxford Tier 1 service £50,000–70,000		Tier 1	£50,000–70,000
Proposed organisational development Initiatives		Relocate psychotherapy and psychology			
Single organisation for forensic care	Axis II Institute				

Catchment	Thames Valley			Identified/Estimated (E) Cost
SHA/LSCG	Berkshire	Oxford and Bucks	Milton Keynes	
Other proposed actions	Prevention and early intervention PD services CAMHS and PD Older people and PD Housing links and PD Links with prison health and CJS Voluntary sector access work PD carer support services			
Implementation costs	Option 2 requires investment of £665,000 revenue and £70,000 capital in addition to TVI budget of £1.58 million		Milton Keynes service start up and accommodation rental £250,000	£665,000 revenue £70,000 capital, total £920,000 revenue £250,000 revenue
Unidentified impacts	Mental health legislation predicts doubling of admissions Prison population need – additional 2,000 patients			

Catchment	Devon, Plymouth and Cornwall		Identified/Estimated (E) Cost	
SHA/LSCG	Devon, Plymouth and Cornwall			
Proposed service development	In-prison PD treatment services Women's secure PD services Medium-secure and community forensic PD services	Tiers 5 and 6		
	Additional inpatient beds	Tier 4		
	Community specialised services User-led Tier 1-3 services	Tiers 2 and 3		
	Service user networks in each of the 3 communities PD carers group	Tier 1		
	Proposed organisational development initiatives	Establish the SWP PD strategy and implementation forum Partnership of 3 Devon Cluster prisons, mental health in-reach and other forensic services to plan additional capacity in response to PD pressures from prisons, high-secure and DSPD		
	Other proposed actions	BME needs assessment Further needs assessment Gap analysis in 2005/06 Development of a consistent service model and pathways Coordination of the infrastructure Roll out EBE Programme Workforce plan Training and education plan Commissioning framework for the area		
Implementation costs				
Unidentified impacts	Leadership process in 3 areas of South West – 2 whole-time equivalent posts until 2008		£120,000 pa	

Catchment	Avon, Gloucestershire and Wiltshire			Identified/Estimated (E) Cost	
SHA/LSCG	Avon	Gloucestershire	Wiltshire		
Proposed service development	Forensic PD services – lead clinician and support staff			Tiers 5 and 6	£200,000–250,000
				Tier 4	
	Specialist PD team Develop improved crisis support Specialist day service	Specialist PD team Day treatment	Day treatment programmes Virtual specialist PD teams	Tiers 2 and 3	Avon £762,000–843,000 + £50,000 capital Wiltshire £195,000 (short term) Gloucestershire £540,000 + £19,500 start up
	PD early intervention services		Increase primary care counselling and psychology	Tier 1	
Proposed organisational development initiatives	Outreach to non-statutory agencies Network of PD self-help groups Promote service user involvement Develop model care pathways		Strengthen local strategic planning groups		
Other proposed actions					
Implementation costs					
Unidentified impacts					

Catchment	Northern			Identified/Estimated (E) Cost	
	SHA/LSCG	County Durham and Tees	Northumberland, Tyne and Wear	Cumbria and Lancashire (part)	
Proposed service development	No recommended development at this stage				
Proposed organisational development initiatives	Development of local partnerships Local commissioners to agree 'whole system' context Need to strengthen links between forensic and non-forensic services				
Other proposed actions	Report to catchment group Form a robust PD steering group Link to NIMHE training initiatives Improvement in overall planning Pathway planning needed Work to develop a managed network Clarify who leads the planning process Improvement in basic data on PD				
Implementation costs	Not identified but Analysis Team estimate				1.5 whole-time equivalent clinical and managerial leads with support £180,000
Unidentified impacts					

Catchment	Yorkshire		Identified/Estimated (E) Cost	
SHA/LSCG	West Yorkshire	North and East Yorkshire and Northern Lincolnshire		
Proposed service development	Inpatient assessment forensic PD service		Tiers 5 and 6	£2 million
	Women's intensively supported hostel			£1.7 million
	Prison and liaison PD psychiatry			£100,000
	Diverse Pathways	Hull Community PD	Tiers 3 and 4	£100,000
	(£100,000)	Service (£250,000)	Tiers 1–3	£250,000
Proposed organisational development initiatives	PD forum reviews and development of collaborative commissioning structures			£250,000 non-recurring
Other proposed actions	Needs assessment			£25,000 non-recurring
Implementation costs	Leadership post			£25,000
Unidentified impacts				

Catchment	Kent, Surrey and Sussex		Identified/Estimated (E) Cost	
SHA/LSCG	Kent and Medway	Surrey and Sussex		
Proposed service development	No development proposals made			
Proposed organisational development initiatives	Improve commissioning arrangements for PD Improve joint agency and multidisciplinary working Improve data on PD service use and need			
Other proposed actions	Identify service and treatment model based on 'whole system' responses and staff capacity Improve access to secure beds Develop community accommodation for people with PDs			
Implementation costs				
Unidentified impacts				

Catchment	West Midlands			Identified/Estimated (E) Cost	
SHA/LSCG	Birmingham and The Black Country	West Midlands (South)	Shropshire and Staffordshire		
Proposed service development	New step-down services for DSPD, high-secure and out-of-area placement returners			Tiers 5 and 6	
	PD provision in new 3rd medium-secure unit				
Proposed service development	Develop a greater spectrum of PD services appropriate for the range of PDs			Tiers 1–4	
	Strengthen substance misuse services re PDs				
Proposed organisational development initiatives	All mainstream services to review access responsiveness re: BME, gender, age				
	Gain commitment of SHAs, commissioners and providers to the capacity plan				
	Develop a 'whole system' approach				
	Agree local policies supporting access and an evidence-based approach to PDs				
Other proposed actions	Develop agreed models of care for PD				
	Improve support for accommodation providers				
	Develop service user-led initiatives				
	Develop a regional network to support 'champions and leadership'				
	Improve BME access				
	Review mental health services criteria to ensure access to appropriate services without discrimination				
	Consider repatriation of PD out-of-area placements				
	Improve support to existing PD services				
	Service redesign to retain the specialist workforce				
	Support service user group development				
	Promote service user evaluation				
	Further commissioning development work				
	Develop a fully costed plan				
Implementation costs					
Unidentified impacts					

Catchment	Eastern (ESMHCG)		Identified/Estimated (E) Cost
	SHA/LSCG	Norfolk, Suffolk and Cambridgeshire	
Proposed service development	Consider regional PD medium-secure unit		Tiers 5 and 6
	Establish hub and spoke in region (£7.5 million)		Tiers 3 and 4
	Crisis support and managing serious ill-health		
	Cambridge Complex Needs Service – self-help and ongoing support (2 posts and infrastructure costs)		Tiers 1 and 2
	Peterborough Day Service		
Proposed organisational development initiatives	Ensure a multi-agency approach and identify a lead director in each mental health trust to implement		
	Each mental health trust to produce plans for specialist PD 'hub and spoke' services		
	Audit mental health PD promotion in line with NSF		
Other proposed actions	<p>Links between the pilot site and CAMHS/young people services should be made</p> <p>Review secure service capacity to provide access and appropriate treatment pathways for people with PDs who are a risk to others</p> <p>Catchment group will ensure service user group arrangements established in each system</p> <p>Catchment group will continue to commission the Henderson service with review</p> <p>Trusts and voluntary sector will be asked to identify the shape and capacity of day services and to consider redesign options</p> <p>Networks to review local commissioning and inter-agency working re:</p> <ul style="list-style-type: none"> <li>– specification for prison in-reach recognises PDs and realistic plans for provision developed</li> <li>– check discharge arrangements are effective</li> <li>– audit and improve local arrangements</li> </ul> <p>Work with DSPD service at Whitemoor to maximise expertise to design and develop PD services</p>		£7.5 million (see above)
Implementation costs			
Unidentified impacts			

Catchment	North West			Identified/Estimated (E) Cost		
	SHA/LSCG	Cumbria and Lancashire	Greater Manchester	Cheshire and Merseyside		
Proposed service development	Only specified development is TCSNW proposal to develop initiatives in the mental health trusts in the region			Tiers 1 and 2		
Proposed organisational development initiatives	PCTs and trusts to review and redesign primary mental healthcare to strengthen PD access					
Other proposed actions	<p>Develop independent/voluntary sector approaches in a review of PD needs of BME people, parents and women</p> <p>Commissioners and trusts to agree criteria for assertive outreach, crisis resolution and early intervention services to include people diagnosable with PDs</p> <p>All agencies to plan the sharing of PD skills</p> <p>Develop community-focused/user-led service initiatives</p> <p>Review capacity of psychological services to meet PD need</p> <p>Mainstream services to respond to people diagnosable with PDs and others with complex needs</p> <p>A&amp;E response to deliberate self-harm to be reviewed</p> <p>Wider clinical debate on treatment models and pathways to be facilitated</p> <p>Strengthen network capacity</p> <p>Learning disability/PD review</p> <p>Older people/PD review</p>					

Catchment SHA/LSCG	North West			Identified/Estimated (E) Cost
	Cumbria and Lancashire	Greater Manchester	Cheshire and Merseyside	
	<p>PCTs to carry out paper review of all out-of-area placements and identify what local PD services might avert placement</p> <p>Introduce local PCT targets to include PD in respect of suicide, mental health promotion, young people's mental health and race equality</p> <p>Improve the provision of intensive community services</p> <p>Work to estimate North West numbers re:</p> <ul style="list-style-type: none"> <li>– PD and complex needs</li> <li>– PD and risk</li> </ul> <p>Consider development of more services able to manage risk</p>			
	<p>Clarify existing pathways from high and medium-secure services to community</p> <p>Develop women's PD strategy in conjunction with development of 'enhanced' secure service</p> <p>Consider single-site PD medium-secure unit</p> <p>Merseyside PD Institute</p> <p>Monitor DSPD placements and step-down requirements</p> <p>Pilot forensic outreach and residential accommodation that does not exclude PD, and ensure prison in-reach services have capability to assess and support prisoners with PDs</p>			
Implementation costs	Regional PD Development Team (senior manager and 0.5 whole-time equivalent senior psychologist + support)			£150,000 per year
Unidentified impacts				

Catchment	East Midlands and South Yorkshire			Identified/Estimated (E) Cost		
	SHA/LSCG	South Yorkshire	Leicester, Northamptonshire and Rutland	Trent		
Proposed service development	Development of dedicated PD services at Arnold Lodge Development of women's PD service at Arnold Lodge Development of women's service contract with Annersley House			Tiers 4 and 5		
Proposed workforce development						
Proposed organisational development initiatives						
Other proposed actions	Clarify care pathways and agree all key organisations All organisations to include the spectrum of PD services in local development plans Mental health services: <ul style="list-style-type: none"> <li>– clarify the potential for community support and recovery workers in linking people into mainstream mental health services</li> <li>– enhance and resource the psychologist role in PD treatment and supervision</li> <li>– review service at Francis Dixon Lodge and Nottingham PD pilot to inform planning</li> <li>– review use of Main House and consider enhancement of Francis Dixon Lodge as local alternative</li> <li>– widen access to Landscape Project</li> </ul>					

Catchment	East Midlands and South Yorkshire			Identified/Estimated (E) Cost		
	SHA/LSCG	South Yorkshire	Leicester, Northamptonshire and Rutland	Trent		
	Criminal justice services: <ul style="list-style-type: none"> <li>– PCTs to consider need in respect of the prison healthcare agenda by reviewing resources and activity of mental health in-reach teams</li> <li>– level of PD need within the prison population</li> <li>– network arrangements in relation to transfer, release and aftercare</li> <li>– Nottingham PD Institute</li> </ul> Secure services: <ul style="list-style-type: none"> <li>– review of existing PD services at Rampton</li> <li>– monitoring and review of out-of-area placements and develop 3-year plan to repatriate</li> <li>– consider impact of DSPD flows on regional capacity</li> </ul>					
Implementation costs						
Unidentified impacts						

Catchment		Dorset and Somerset		Identified/Estimated (E) Cost
SHA/LSCG	Dorset	Somerset		
	Dorset Healthcare Trust Specialist PD Team (£575,000) North Dorset PCT Virtual PD Team (£128,000)	Somerset Partnership Trust Specialist PD Team (£212,000)	Tiers 1 and 2	£212,000 (E) £575,000 + £170,500 start up (E) £128,000 (E)
Proposed workforce development				
Proposed organisational development initiatives	PD commissioning development plan			
Other proposed actions	2nd stage planning by 30 September 2005 Consider existing service redesign Consider PD development in primary care Access capacity and role of CMHTs Links between Tiers 1–3 and Tiers 4–6 Develop plans for mental health/PD services for prisoners in Dorset and Somerset Develop an EBE network			
Implementation costs				
Unidentified impacts				

Catchment	London					Identified/Estimated (E) Cost
	SHA/LSCG	North East	North West	Central	South East	
Proposed service development	Tiers 1 and 2 enhancement with worker in each PCT					£36,000 (CE)
Proposed workforce development						
Proposed organisational development initiatives						
Other proposed actions	PD care pathways analysis to be done Service design work to ensure consistency across London (event) Analysis of models and evidence base (not costed but CP analysis team estimate made) User-led initiatives to be supported (not costed) Develop protocols for partnership arrangements (not costed) Identify primary care PD gaps (not costed) Review access and appropriate of services for BME people with PDs (not costed)					£8,000 non-recurring £500 non-recurring £25,000 (E) non-recurring £1 million (E)
Implementation costs						
Unidentified impacts						

Forensic Capacity Plan (Tiers 4–6) Kent, Surrey, Sussex, South West Peninsula, Thames Valley, Wessex (Central South Coast) West of England. NOT PD-specific				Identified/Estimated (E) Cost	
SHA/LSCG	Kent/Medway and Surrey/Sussex	South West Peninsula	Thames Valley		
Proposed service development	20 beds at Trevor Gibbens Unit 10 beds at Ashden Hill Unit 6 supported hostel places	10 low-secure beds at Bodmin Women's unit at Langdon site		Tiers 5 and 6	
		High-support housing in Plymouth Redevelopment of the Leander Unit for PD	30-bed learning disability facility (not sited)	Tiers 3 and 4	
Proposed workforce development					
Proposed organisational development initiatives					
Other proposed actions	Agreements to: <ul style="list-style-type: none"> <li>– a 'whole system' view and extended collaboration across the area</li> <li>– better exit planning</li> <li>– proper debate about learning disability in the South to resolve the 'risky', 'challenging' debate and its relationship to PD</li> <li>– catchment group planning process to consider justification of NHS versus private sector PD developments</li> </ul>				
Implementation costs					
Unidentified impacts					

Catchment	South	Identified/Estimated (E) Cost
<b>SHA/LSCG</b>	<b>Hampshire and Isle of Wight</b>	
Proposed service development	Continue the piloting of deliberate self-harm service in Basingstoke	
Proposed organisational development initiatives		
Other proposed actions	Further consultation on capacity plan Protocol and prevention work Training mental health teams in DBT due for completion in November 2005 Tier 3 focus to be on substance misuse and eating disorder services	
Implementation costs		
Unidentified impacts		



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