NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Springbank Ward

Improving services for people diagnosable with Personality Disorder. An inpatient perspective.

Dr Jorge Zimbron
27th September 2022

Pride in our adults and specialist mental health services

SPRINGBANK WARD

Opened May 2011

Unique in the NHS

- Most of these patients go to the private sector.

Inclusion

- Women, trans, and non-binary
- Severe Borderline Personality Disorder
- **Co-morbidity is the norm**
- Failure to manage in the community / acute wards

Treatment

- 12 beds
- 1 year programme
- DBT, pharmacotherapy, occupational therapy, music therapy, physiotherapy, and others

OUTLINE

The Guidance

The System

The Culture

Areas to Improve

Helpful facts and tips

Discussion & Q&A

THE GUIDELINES

NICE GUIDELINES BORDERLINE

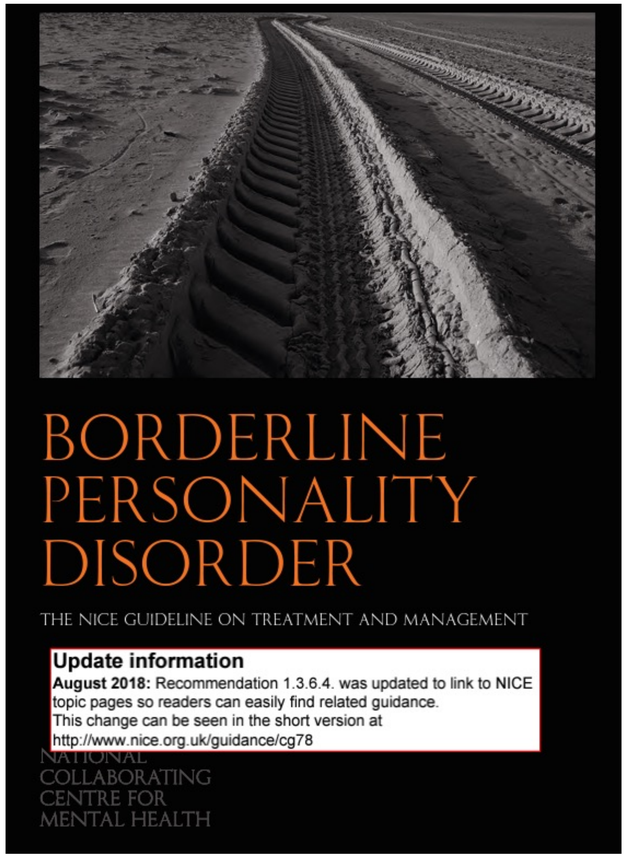
No medication

- Crisis management
- Promethazine (1 week)

Psychological interventions

Inpatient treatment

- Short-term management of acute risk
  - ‘significant risk to self or others’
- Assess and treat co-morbidities
- Detention under MHA
  - Extreme circumstances
- Involve patient and agree duration



MEDICATION HABITS

Europe (2015)

Prescription analysis

2001 – 2011

90% on psychotropics

- 80% > 2
- 54% > 3

Antipsychotics / Antidepressants 70%

- Quetiapine 22%

Anticonvulsants 33%

Benzodiazepines 30%

Lithium 4%

Psychopharmacological treatment of 2195 in-patients with borderline personality disorder: A comparison with other psychiatric disorders

René Bridler, Anne Häberle, Sabrina T. Müller, Katja Cattapan, Renate Grohmann, Sermin Toto, Siegfried Kasper, Waldemar Greil

PlumX Metrics

DOI: https://doi.org/10.1016/j.euroneuro.2015.03.017 | CrossMark

Article Info

PD PREVALENCE IN INPATIENT SETTINGS

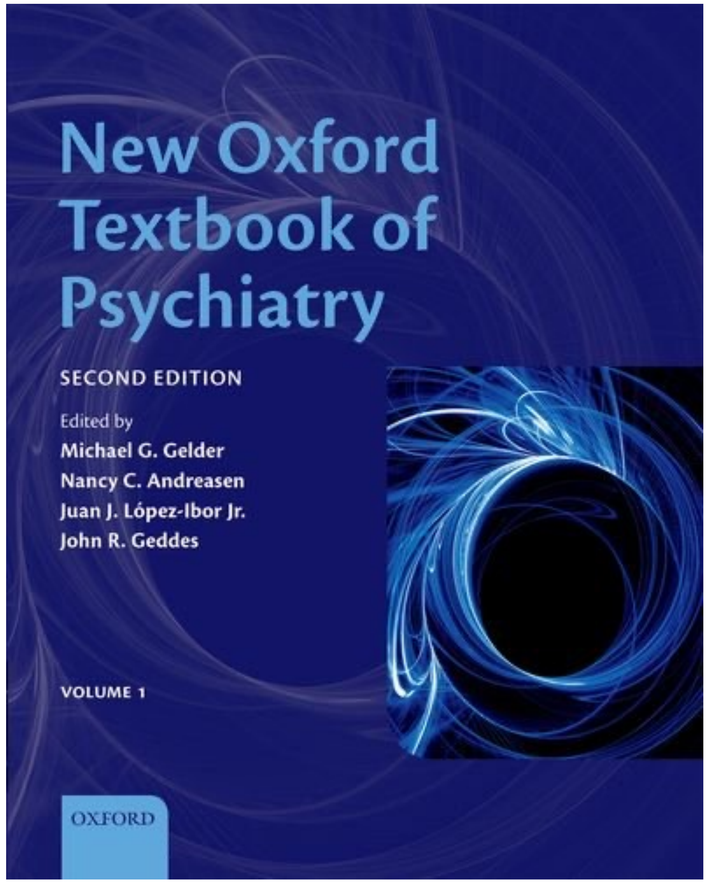
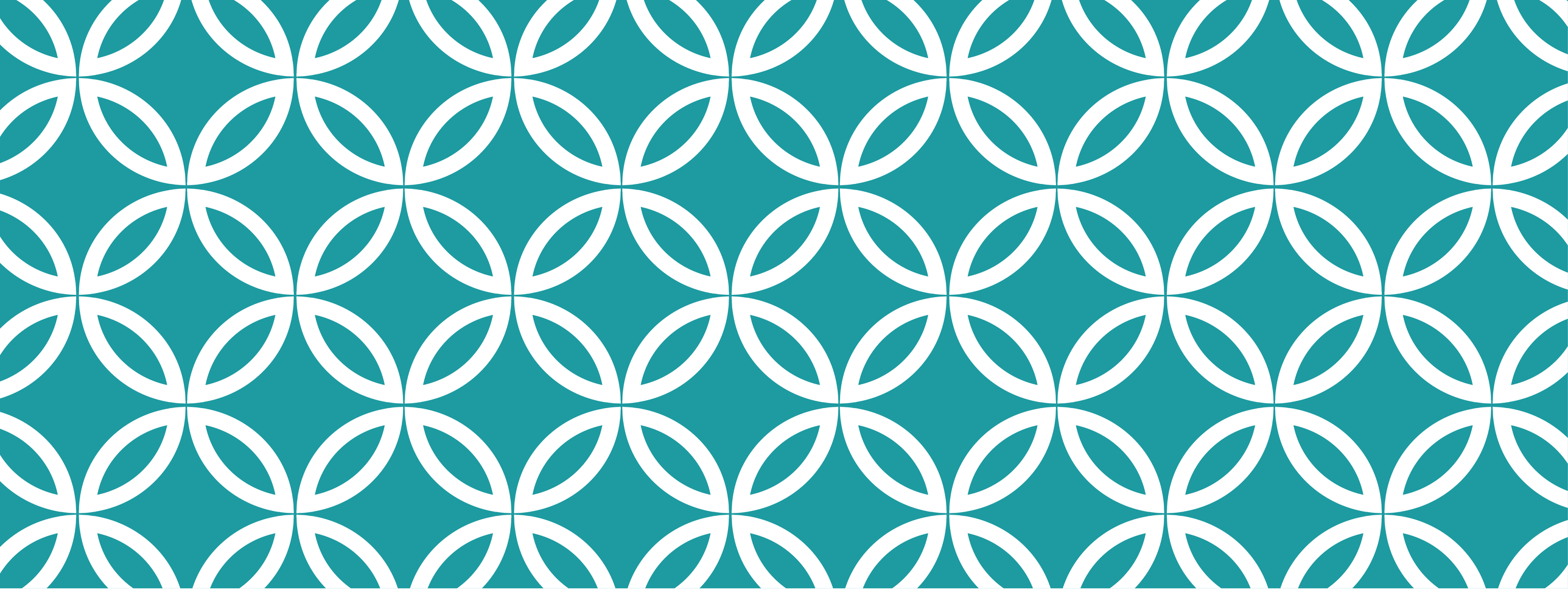


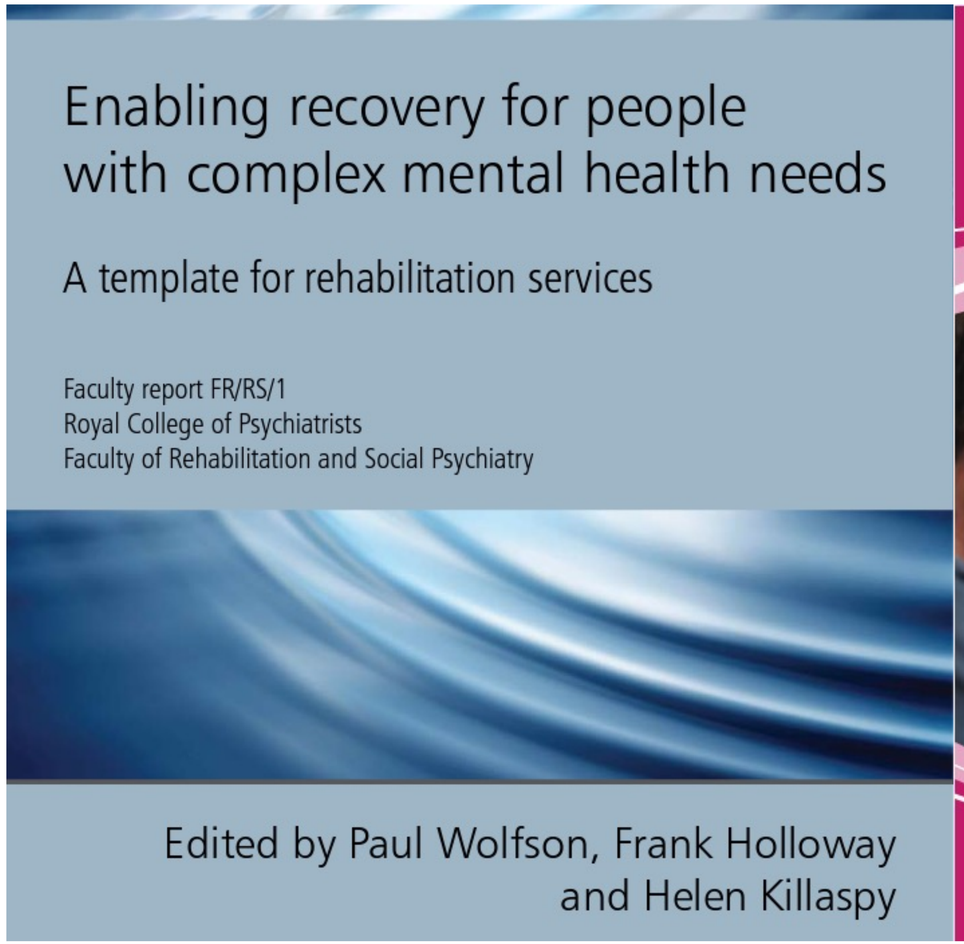
Table 4.12.4.3 Median prevalence rates of PDs among psychiatric patients in prospective studies including more than 100 subjects

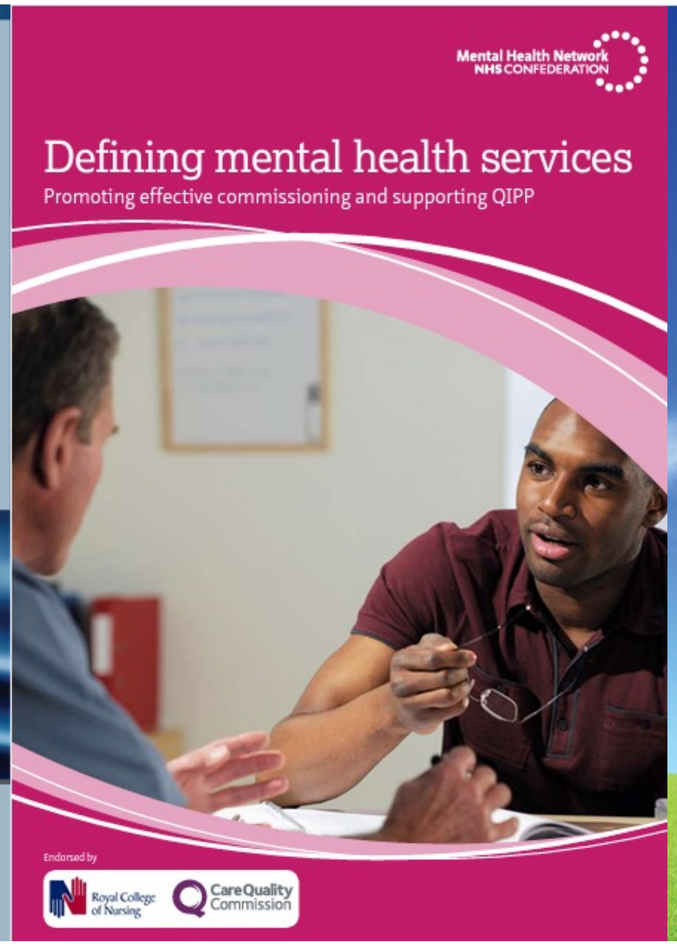
Diagnostic category	Number of studies (*N*)	Median sample (*N*)	Median prevalence rates (%)
Alcohol and substance abuse	15	250	57.0
Affective disorder	19	200	49.2
Anxiety disorders	7	200	40.4
Any Axis disorder	20	131	51.0



THE SYSTEM

INPATIENT TREATMENT IN MENTAL HEALTH: IT IS ABOUT PSYCHOSIS





2009 2012 2016

HOSPITAL ADMISSIONS

Acute

'Acute wards'

- <90 days

PICUs

- Few days to weeks

Rehabilitation

Unit Type	Length of stay	Site	Risk-management	Resource suggested as per population size	Funding
High Dependency	1 – 3 years	Hospital	Locked	1 unit per 600,000 – 1 million	CCG
Long-term Complex	"several years"	Hospital	Locked	1 unit per 600,000 – 1 million	CCG
Community	Up to 1 year	Community	Open	1 unit per 300,000	CCG
Secure	>2 years	Hospital	Locked	Low secure: 1 per million. High secure: 1 per 15 million Medium secure: somewhere in between	NHS England
Highly Specialist	1-3 years	Hospital	Varies with risk profile	1 per "several million"	CCG
Tier 4	Varies	Hospital	Varies with risk profile	1 unit per 300,000 – 600,000	NHS England

In area & Out of Area Placements (OAPs)

Unit Type	Length of stay	Site	Risk-management	Resource suggested as per population size	Funding
High Dependency	1 – 3 years	Hospital	Locked	1 unit per 600,000 – 1 million	CCG
Long-term Complex	“several years”	Hospital	Locked	1 unit per 600,000 – 1 million	CCG
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Tier 4	Varies	Hospital	Varies with risk profile	1 unit per 300,000 – 600,000	NHS England

‘Locked-rehab’ is not a ward type

COST

PAYING THE PRICE

The cost of mental health care in England to 2026

Paul McCrone
Sujith Dhanasiri
Anita Patel
Martin Knapp
Simon Lawton-Smith

King's Fund

TABLE 1: NUMBER OF PEOPLE WITH SPECIFIC DISORDERS AND CURRENT AND PROJECTED COSTS

Disorder	Number of people (million)		Service costs (£ billion)			Lost earnings (£ billion)			Total costs (£ billion)		
	2007	2026	2007	2026 (2007 prices)	2026 including real pay and price effect[c]	2007	2026 (2007 prices)	2026 including real pay and price effect[c]	2007	2026 (2007 prices)	2026 including real pay and price effect[c]
Depression	1.24	1.45	1.68	2.03	2.96	5.82	6.31	9.19	7.50	8.34	12.15
Anxiety disorders	2.28	2.56	1.24	1.40	2.04	7.7	8.34	12.15	8.94	9.74	14.19
Schizophrenic disorders	0.21	0.244	2.23	2.52	3.67	1.78	1.94	2.83	4.01	4.46	6.5
Bipolar disorder/ related conditions	1.14	1.23	1.64	1.8	2.63	3.57	3.83	5.58	5.21	5.63	8.21
Eating disorders	0.117	0.122	0.016	0.016	0.024	0.035	0.036	0.052	0.051	0.052	0.076
Personality disorder[a]	2.47	2.64	0.7	0.78	1.13	7.2	7.65	11.16	7.9	8.43	12.29
Child/adolescent disorders[b]	0.61	0.69	0.14	0.16	0.24	0	0	0	0.14	0.16	0.24
Dementia[b]	0.58	0.94	14.85	23.88	34.79	0	0	0	14.85	23.88	34.79
Total	8.65	9.88	22.5	32.59	47.48	26.1	28.1	40.97	48.6	60.69	88.45

Notes: [a] The costs for personality disorders related to 64.6 per cent of people with the condition (*see* Chapter 9). [b] The total costs are the same as the service costs as we have assumed that there is no lost employment for people with these conditions. [c] It has been assumed that real pay and prices increase by two percentage points above the GDP deflator.

AMBITION

2016

End ‘inappropriate acute OAPs’ by 2020-21.

- Inappropriate = sent OOA as no local bed available.

NHS Digital starts collecting data

*No ambition to end ‘rehabilitation’ OAPs

Department of Health & Social Care

Guidance

Out of area placements in mental health services for adults in acute inpatient care

Published 30 September 2016

Contents

Out of area placements

Out of area placements decision tree

Patient experience

Annex A: Flowchart description

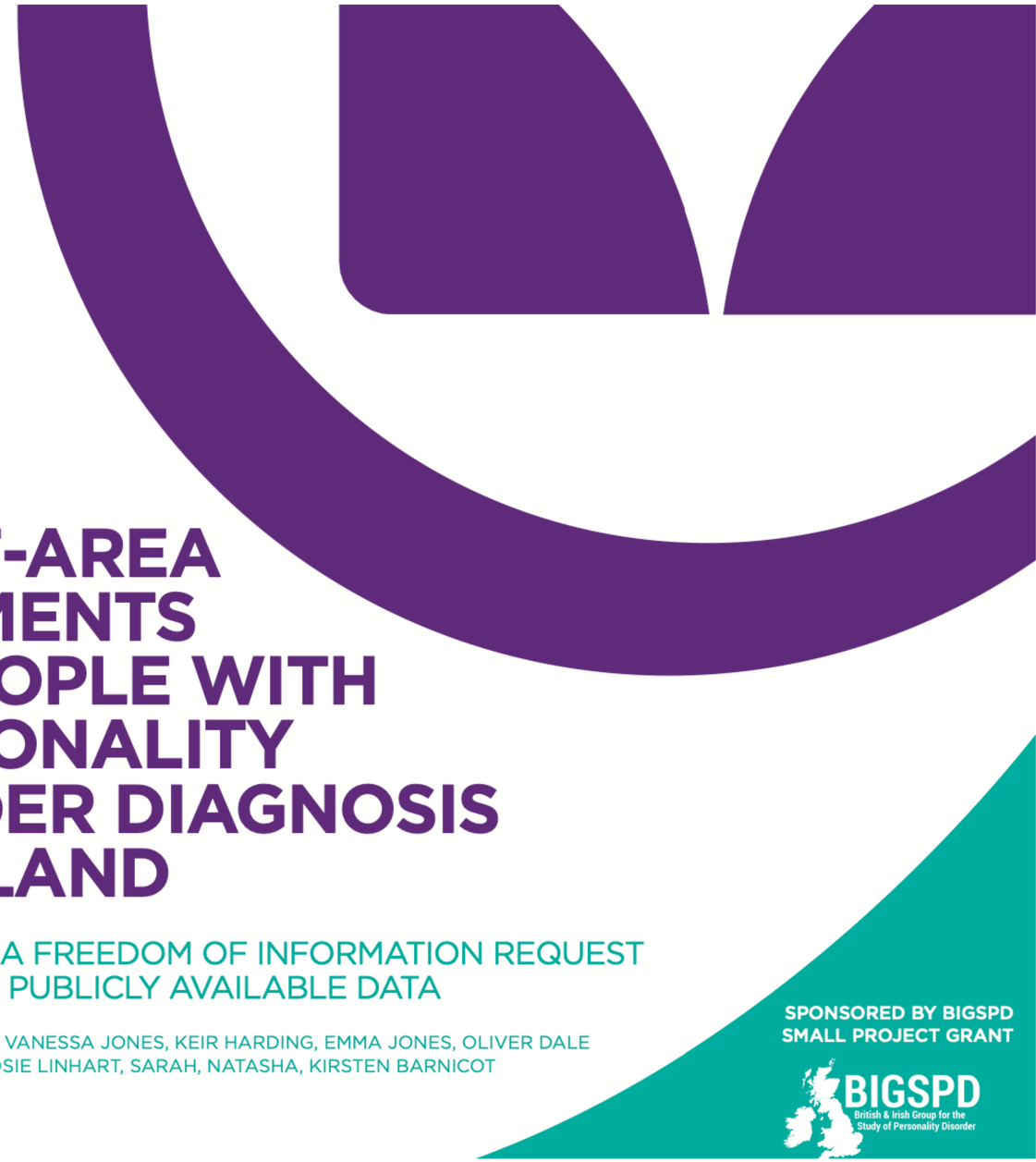
The government has set a national ambition to eliminate inappropriate out of area placements (OAPs)[footnote 1] in mental health services for adults in acute inpatient care by 2020 to 2021. This definition of OAPs has been developed following significant stakeholder engagement to enable progress against the ambition to be monitored. It is aimed at providers, commissioners and users of local adult inpatient acute mental health services in England.

BIGSPD REPORT

FOI data

Lived Experience

Public information available on acute OAPs



KARINA

Throughout my time as an inpatient, I was transferred numerous times to different hospitals, and, more often than not, these units would be miles away from my home and family.

One of the units that I got sent to was 2 and ½ hours away from home and during the time I spent there I was treated horrendously. I was restrained daily and could be injected with sedative medication up to 3x a day, usually without being given the option of oral PRN, or even the chance to discuss why I was feeling so distressed with a staff member.

I had a similar experience, when I was once again transferred out of area to another unit 2 hours away from my home.

I had to wear an anti-ligature dress and was denied access to my underwear. This meant I had to wrap a blanket around my waist whenever I sat down, despite there being an option of a two-piece garment.

I was also restrained and injected regularly without being offered time to talk or oral medication. I remember a few specific memories from this unit which include a time when a nurse decided to inject me, (despite me saying I will take oral medication) just because I was crying.

Another traumatic memory I have is of me sitting in the corner of my bedroom very upset, and the staff member on my 1-1 decided to pull me across the floor by my anti-ligature suit so that she could apparently watch me better, instead of talking to me about what was upsetting me and asking me if I could move.

Neither of these units offered a reliable form of therapy and it was very hard to build up a trusting relationship with the staff. The impression I now get of these two units is the staff genuinely cared more about their liability as a hospital than caring and giving quality time to their patients.

PERSONALITY DISORDER IN OOA

FOI (3,541 placements)

- 11%

Published acute

- FOI period (24,540)
  - 22% (underestimate)
- Feb 2021 (7,145)
  - 9%

Duration (71 days)

Costs (£12-27m)

Comorbidities

Providers (Priory and Cygnet 71%. NHS 1%)

MHA (67% FOI)

Discharge (no specialist PD aftercare)

LAINGBUISSON REPORT

13.5% of the NHS MH budget goes to the independent sector.

10,123 private beds

- NHS 17,610

15-20% profit margins

Lack of competition

- 4 providers get 2/3 of the money
- 71 facilities inadequate

NHS

NHS paying £2bn a year to private hospitals for mental health patients

Exclusive: Fears grow that bed shortages have left NHS increasingly reliant on independent sector

'I thought she'd be safe': a life lost to suicide in a place meant for recovery

Denis Campbell *and* Anna Bawden

Sun 24 Apr 2022 15.00 BST

THE CULTURE

RISK MANAGEMENT

2 treatment models:

- Old (May 2011 – April 2015)
  - Risk Containment
- New (May 2015 – Present)
  - Autonomy

ISSUE: FEAR

Staff

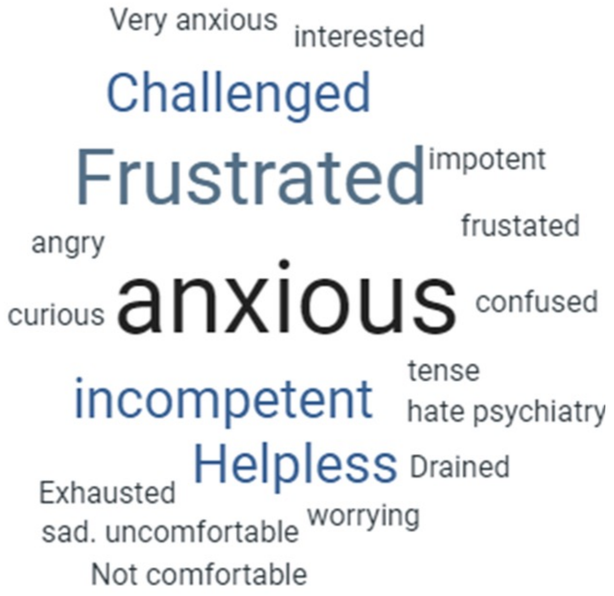
- Complexity
  - Ignorance
- Death
  - Legal system
  - Media
- Security
  - Career
  - Reputation
- Burn-out

Patient

- Death
- Disability
- Life-sentence
- Loss of support

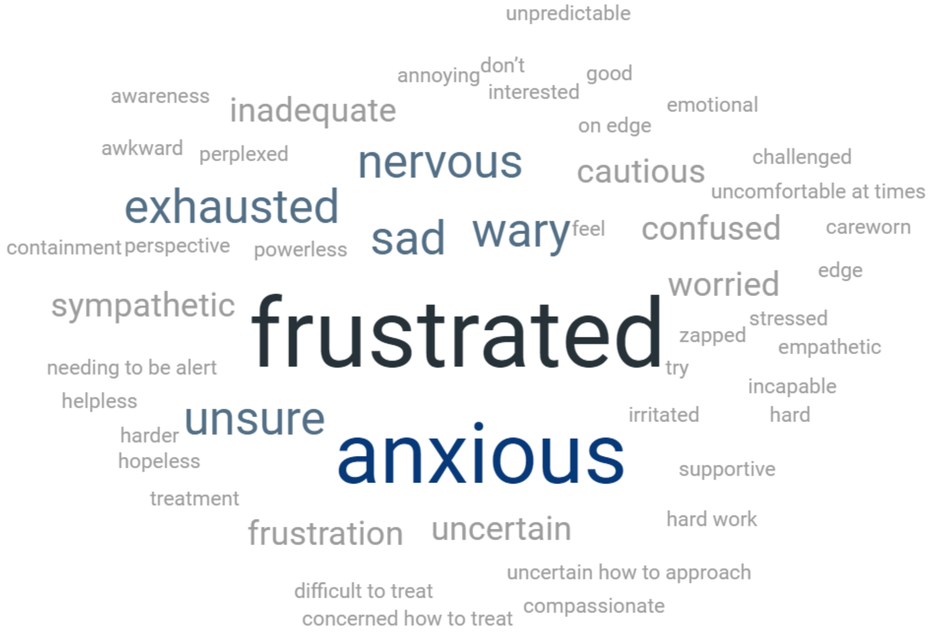
HOW DO PEOPLE WITH A PERSONALITY DISORDER MAKE YOU FEEL?

18 psychiatrists
(consultants and trainees)
November 2020

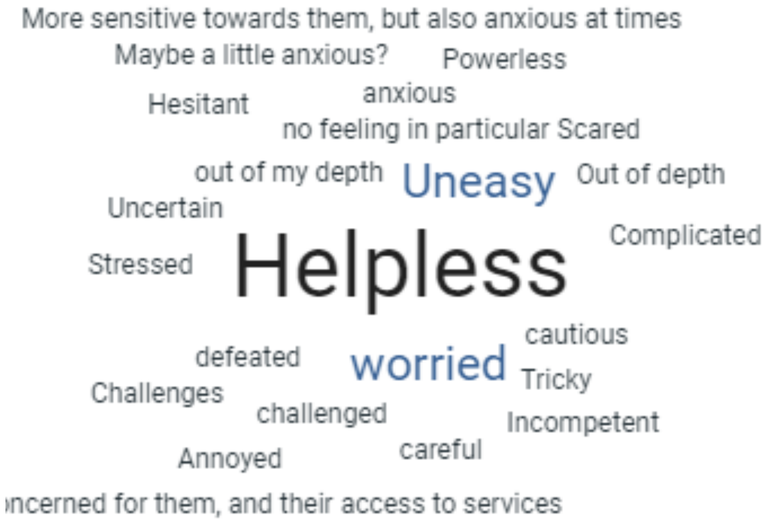


61 pharmacists.

10th Annual International
Psychiatric Pharmacy Conference.



29 GPs and staff in primary care
15.03.2021



LIFE EXPECTANCY

J Psychosom Res. 2012 Aug;73(2):104-7. doi: 10.1016/j.jpsychores.2012.05.001. Epub 2012 May 26.

Life expectancy at birth and all-cause mortality among people with personality disorder

Marcella Lei-Yee Fok [1], Richard D Hayes, Chin-Kuo Chang, Robert Stewart, Felicity J Callard, Paul Moran

Affiliations + expand

PMID: 22789412 DOI: 10.1016/j.jpsychores.2012.05.001

Abstract

Objective: It is well established that serious mental illness is associated with raised mortality, yet few studies have looked at the life expectancy of people with personality disorder (PD). This study aims to examine the life expectancy and relative mortality in people with PD within secondary mental health care.

Methods: We set out to examine this using a large psychiatric case register in southeast London, UK. Mortality was obtained through national mortality tracing procedures. In a cohort of patients with a primary diagnosis of PD (n=1836), standardised mortality ratios (SMRs) and life expectancies at birth were calculated, using general population mortality statistics as the comparator.

Results: Life expectancy at birth was 63.3 years for women and 59.1 years for men with PD-18.7 years and 17.7 years shorter than females and males respectively in the general population in England and Wales. The SMR was 4.2 (95% CI: 3.03-5.64) overall; 5.0 (95% CI: 3.15-7.45) for females and 3.5 (95% CI: 2.17-5.47) for males. The highest SMRs were found in the younger age groups for both genders.

Conclusion: People with PD using mental health services have a substantially reduced life expectancy, highlighting the significant public health burden of the disorder.

177	Angola	**62.22**	65.12	59.46
178	Zimbabwe	**62.16**	63.66	60.39
179	Togo	**62.13**	63.08	61.16
179	Mozambique	**62.13**	64.95	59.05
180	DR Congo	**61.60**	63.21	60.01
181	Eswatini	**61.05**	65.67	56.98
182	Mali	**60.54**	61.39	59.69
183	Cameroon	**60.32**	61.66	58.99
184	Equatorial Guinea	**59.82**	61.08	58.76
185	Guinea-Bissau	**59.38**	61.33	57.31
186	Côte d'Ivoire	**58.75**	60.13	57.50
187	South Sudan	**58.74**	60.31	57.21
188	Somalia	**58.34**	60.11	56.62
189	Sierra Leone	**55.92**	56.78	55.01
190	Nigeria	**55.75**	56.75	54.80
191	Lesotho	**55.65**	58.90	52.52
192	Chad	**55.17**	56.65	53.73
193	Central African	**54.36**	56.58	52.16

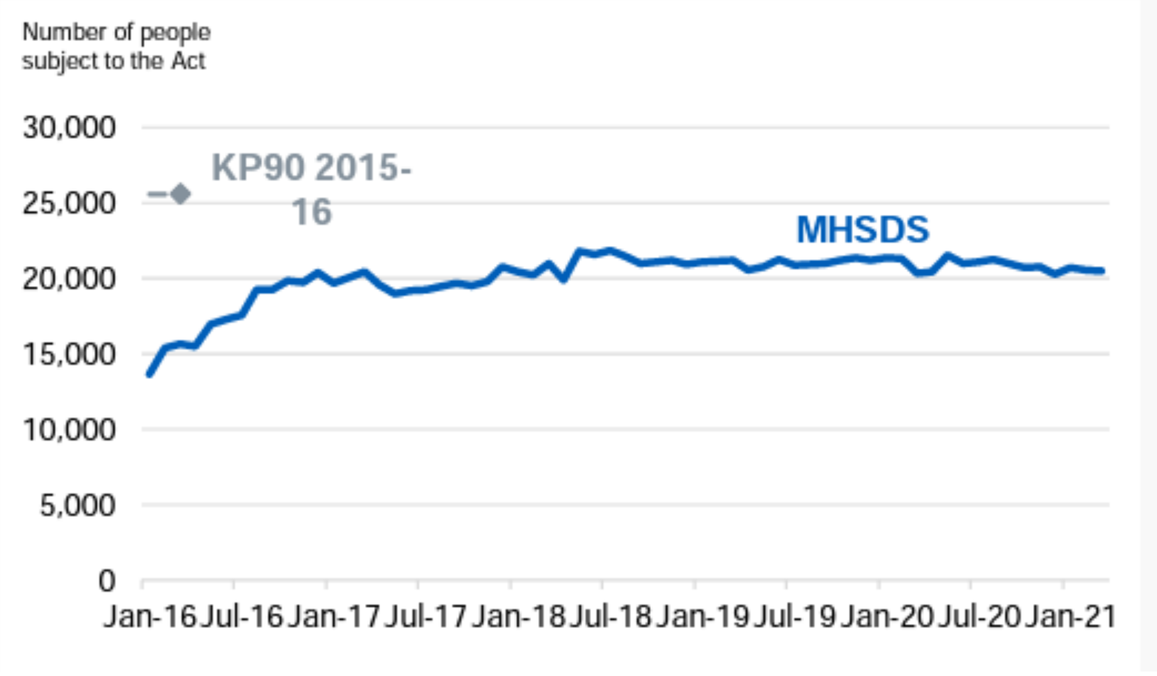
Publication, Part of Mental Health Act Statistics, Annual Figures

Mental Health Act Statistics, Annual Figures - 2020-21

Official statistics, National statistics

Publication Date:	26 Oct 2021
Geographic Coverage:	England
Geographical	Mental Health Trusts, NHS Trusts, Independent Sector Health Care
Granularity:	Transformation Partnerships
Date Range:	01 Apr 2014 to 31 Mar 2021

The number of people reported in the MHSDS as subject to the Act at each month-end[8] has increased from 13,628 on 31st January 2016 to 20,494 on 31st March 2021. This compares to 25,577 people recorded in the last annual publication sourced from the KP90 (on 31st March 2016).



MAKE SOME RULES

Ward opens

- -> some rules

-> incident happens

- -> people get into trouble
- -> ‘risk assessment’
- -> new rules
- -> new incidents….

THE (UNWRITTEN) RULES AT SPRINGBANK

Smoking hours

- 9:30am (if all awake) - 11:00pm

Leave

- Returning to the ward from leave by 9pm
- No leave after 11pm
- No holidays

Access

- Rooms are locked in daytime hours.
- Visiting hours

Plastic cutlery and crockery

No alcohol

RISK CONTAINMENT MODEL (2011 -2015)

Therapies

- Medication
- **Dialectical Behaviour Therapy**
- Occupational Therapy
- Seclusion
- Exercise
- Physiotherapy

Delivery

- **Excellent NHS staff**
- MHA
- Locked ward
- Restricted items
- Personal searches
- Restricted leave
- Punishment / Reward approach
- Observation levels
- Physical restraint & rapid tranquilisation
  - 'Adverse adulthood experiences!'

RISK CONTAINMENT

Goal: *keep person alive*

For acute modifiable risks

In-patient treatment

MHA

Containment **Autonomy**

Assumptions

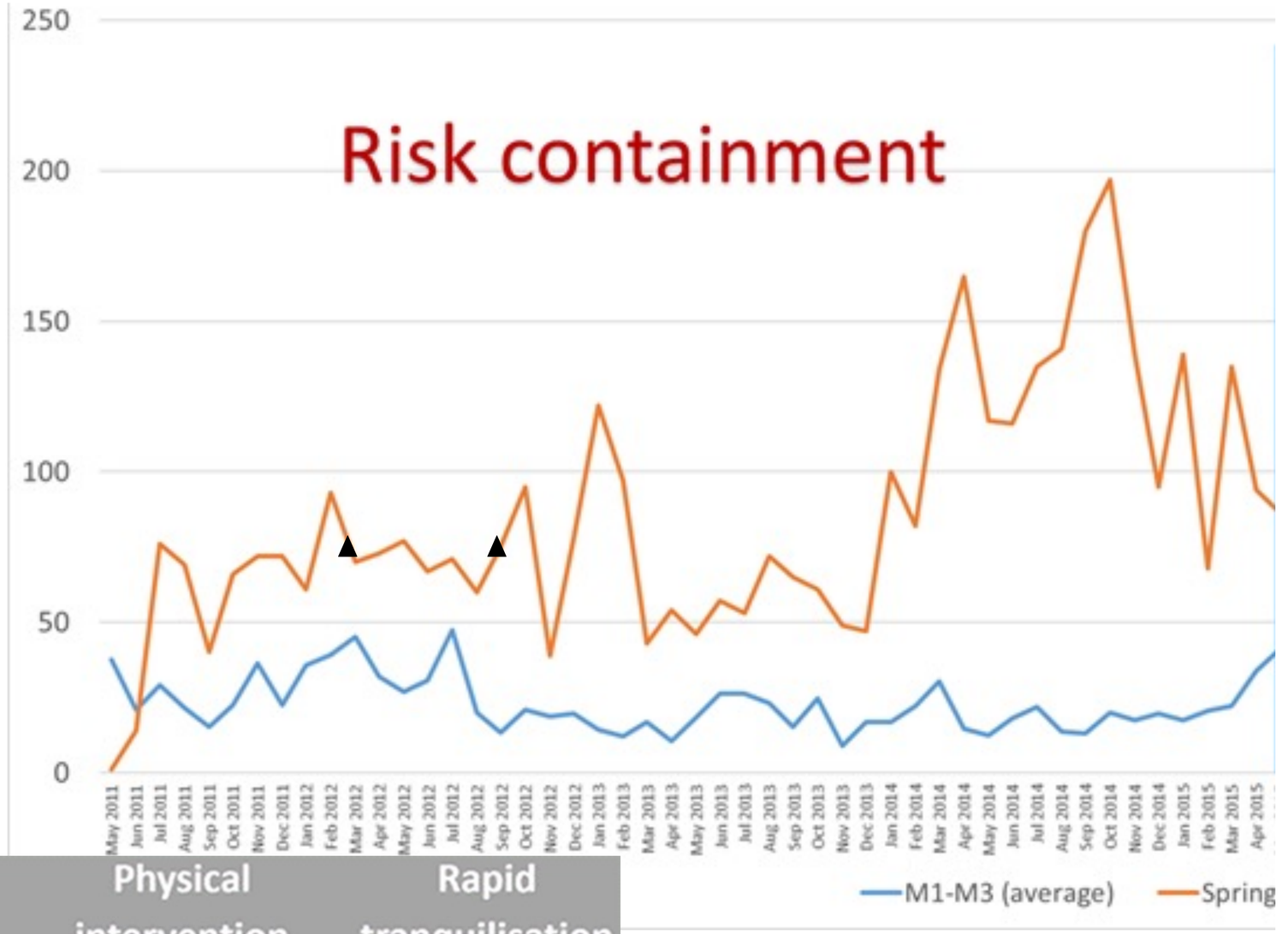
- Hospitals are safer
- Patients/SUs lack capacity

Pros:

- "Feels safe"
- Short-term benefit

Cons:

- "Feels wrong"
- Promotes dependence



Year	Physical intervention	Rapid tranquilisation
2012	52	36
2013	57	45
2014	59	44
2015	64	18

EXPERIENCE

Incidents

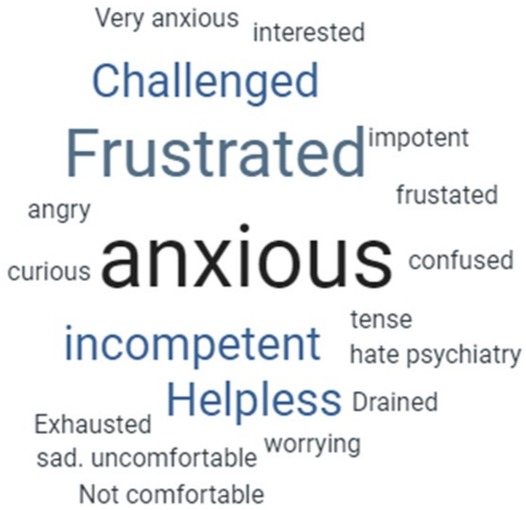
- Daily alarms
- Regular physical interventions
- Frequent injuries

Staff vacancies

- High turn-around
- 7 consultants in 4 years

Ward Reputation

- Difficult place to work
- Difficult group of patients
- Students not allowed



AMBITION

Reduce incidents

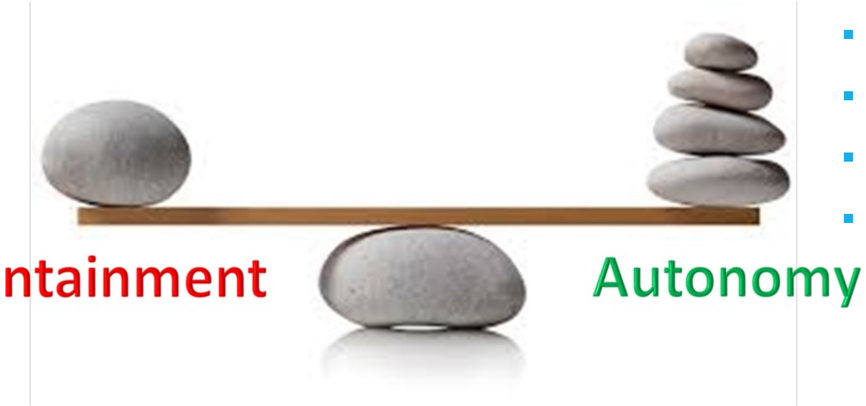
Improve safety

Improve patient and staff experience

NEW SPRINGBANK MODEL (2015 – 2021)

Therapies

- Medication
- **Dialectical Behaviour Therapy**
- Occupational Therapy
- Sensory integration
- Exercise
- Physiotherapy



Delivery

- **Excellent NHS Staff**
- Least-restrictive approach
  - MHA avoided
- **Capacity is assumed**
  - Even in crises
- Recovery focus
- Patient centred care
- **Positive-risk-taking**
- **Shared-decision making**
- **Shared values**
- **Co-production**
- Distributed leadership
- Therapeutic community

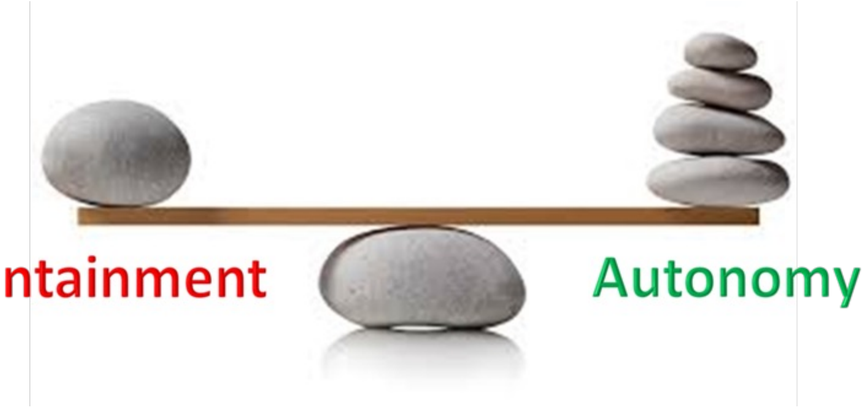
POSITIVE RISK TAKING

Goal: ***Enable people to manage and enjoy life***

Looks at long-term risks and opportunities

Requirements:

- Clear formulation
- Detailed history
- Good relationships
- Communication with relatives
- Organisational support



POSITIVE RISK TAKING

Assumes no risk-free option

Assumes capacity

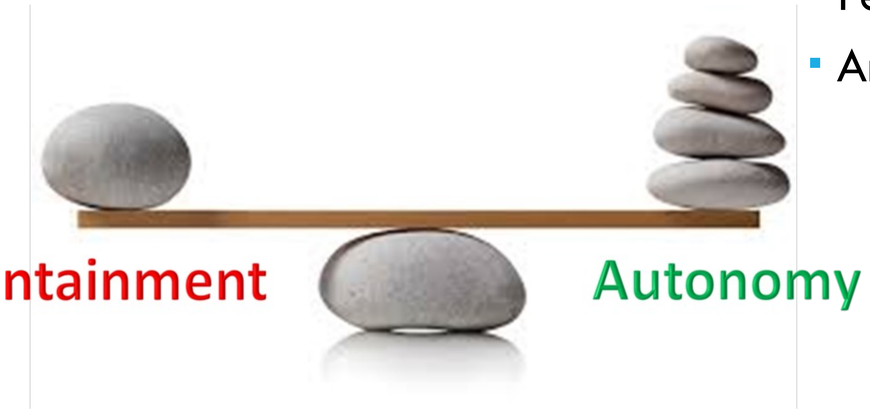
Assumes chronic risk

Pros:

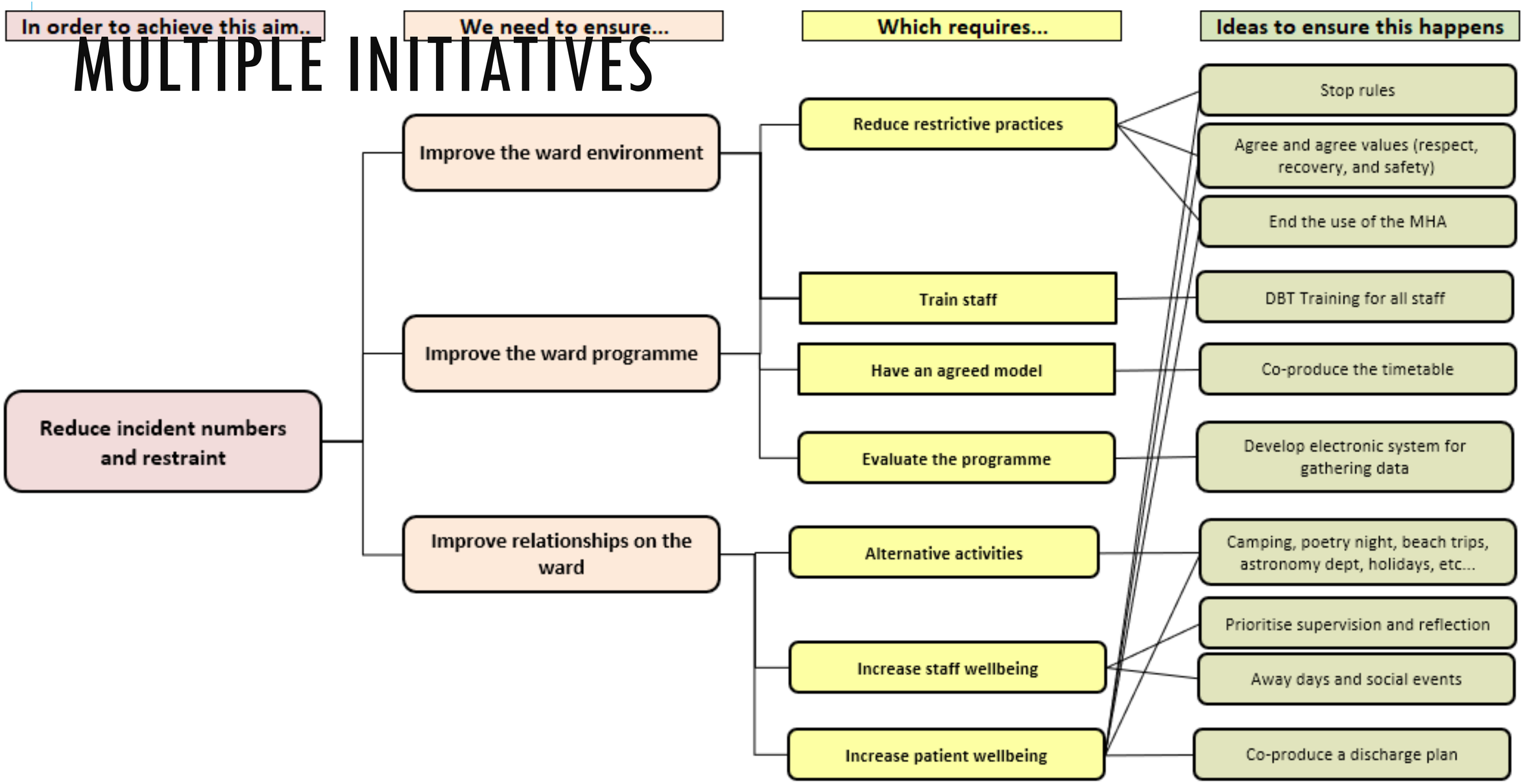
- Promotes autonomy
- Long-term benefits
- “Feels right”

Cons:

- Short-term risks
- Perceived as neglect
- Anxiety-provoking



MULTIPLE INITIATIVES



POSITIVE RISK TAKING
~~THE RULES~~

~~- Smoking hours~~
  - ~~9:30am (if all awake) - 11:00pm~~

~~- Leave~~
  - ~~Returning to the ward from leave by 9pm~~
  - ~~No leave after 11pm~~
  - ~~No holidays~~

~~- Access~~
  - ~~Rooms are locked in daytime hours.~~

~~- Plastic cutlery and crockery~~

~~- No alcohol~~

=

Values

that guide us

Respect

- Be honest with staff
- Quiet if smoking at night
- Quiet returning from leave late

Recovery

- Attend ward programme
- Co-produce the programme
- Leave that is meaningful
- Plan discharge

Safety

- Drink in moderation
- Keys to rooms
- Normal cutlery and crockery

KNOWLEDGE AND UNDERSTANDING

Staff nurturing

- Clinical Supervision
- Reflective Practice
- Case discussions
- Educational activities
- Away days

As a result:

- Increased recruitment
- Increased retention

THE TEAM

POSITIVE RISK TAKING

Removal of long-term observations

Resisting pressures from ‘above’ to avoid risk.

Removal of sections of the MHA

Allowing patients to leave the ward at any point

Constant team discussions

IT IS TRICKY

CAMBRIDGE news

Courtyard next to Grand Arcade is evacuated because of police incident

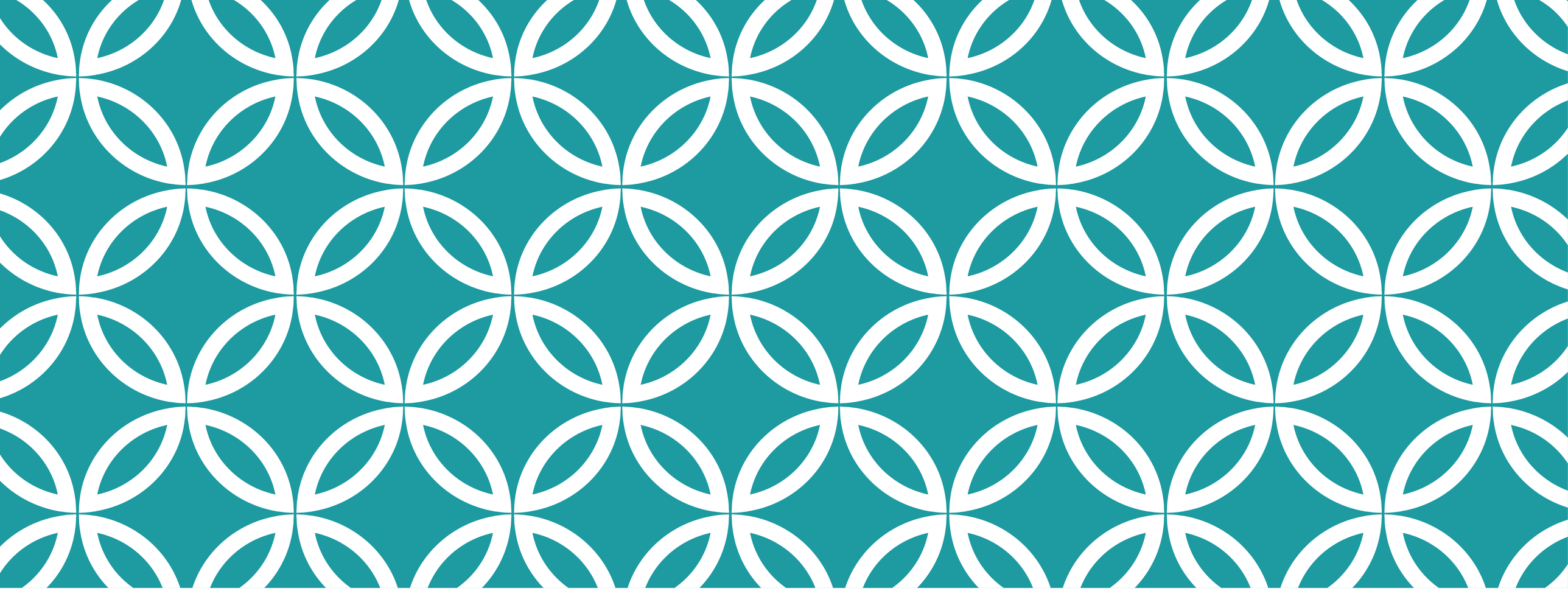
Police moved members of the public away from Fisher Square next to Carluccio's and the Grand Arcade

BY ANNA SAVVA
19:23, 16 MAY 2017 | UPDATED 19:30, 16 MAY 2017

The unidentified woman was spotted on the roof of the Grand Arcade car park

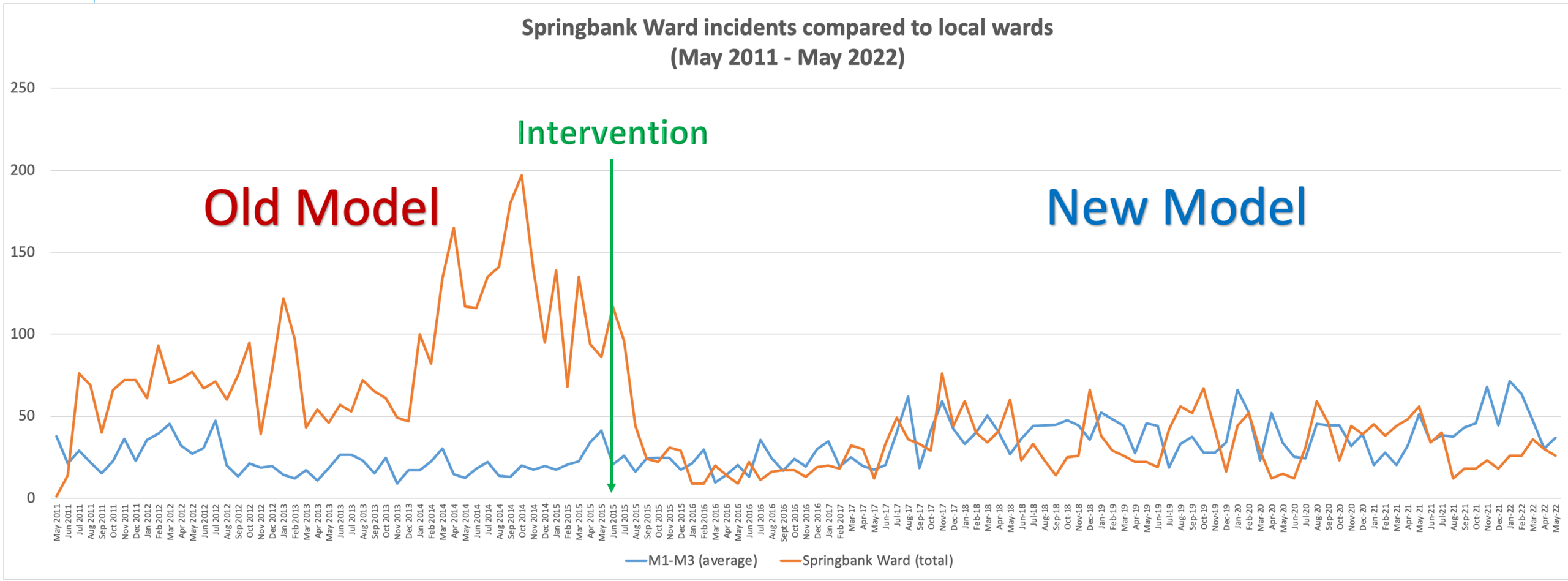
Shoppers were evacuated from the courtyard next to the Grand Arcade after a woman was spotted clinging to a nearby roof.

Police officers cordoned off the area around Carluccio's in Fisher Square at around 6.30pm to deal with the incident and moved away members of the public.



OUTCOMES

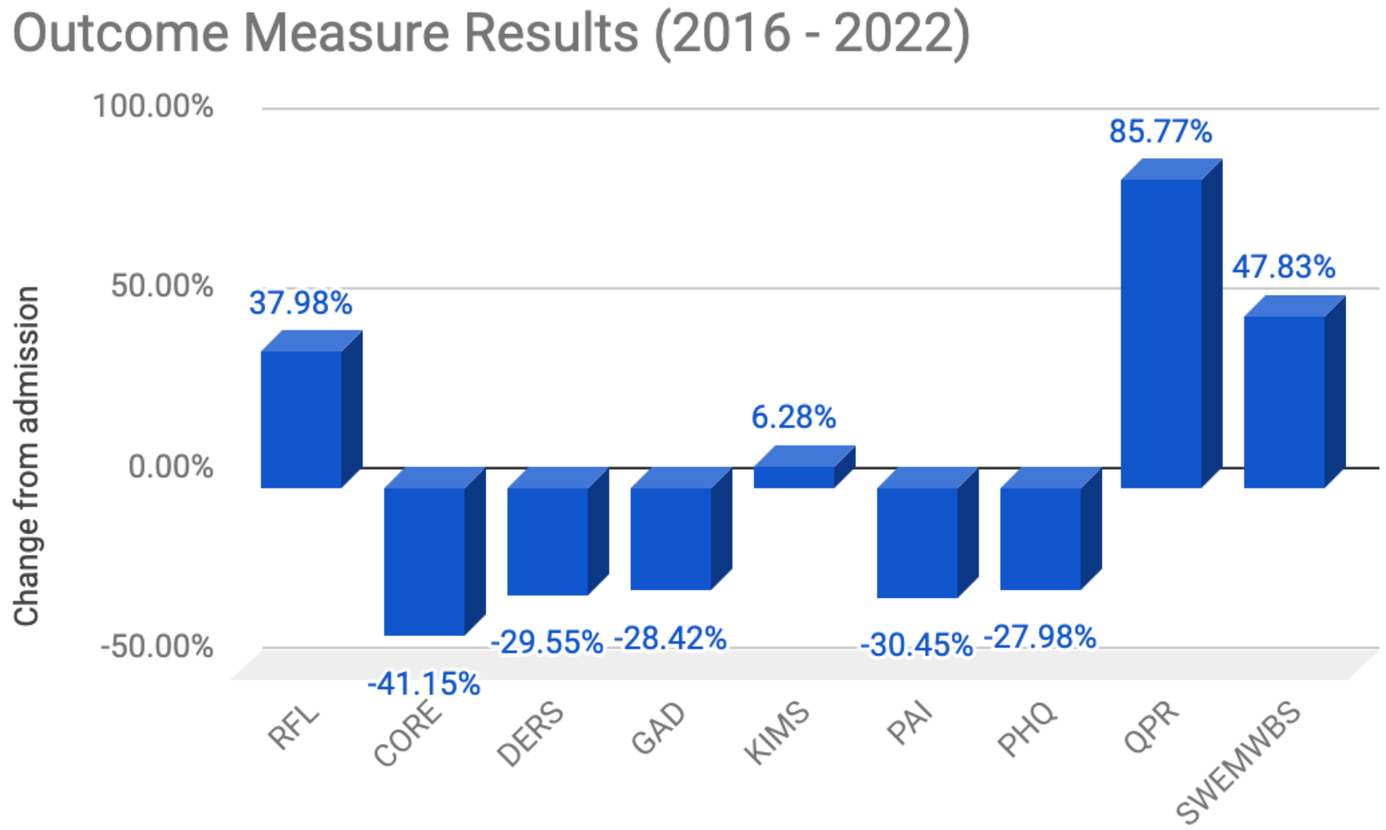
INCIDENTS


Springbank Ward incidents compared to local wards
(May 2011 - May 2022)
Intervention
Old Model
New Model
250
200
150
100
50
0
M1-M3 (average)
Springbank Ward (total)

PHYSICAL INTERVENTIONS

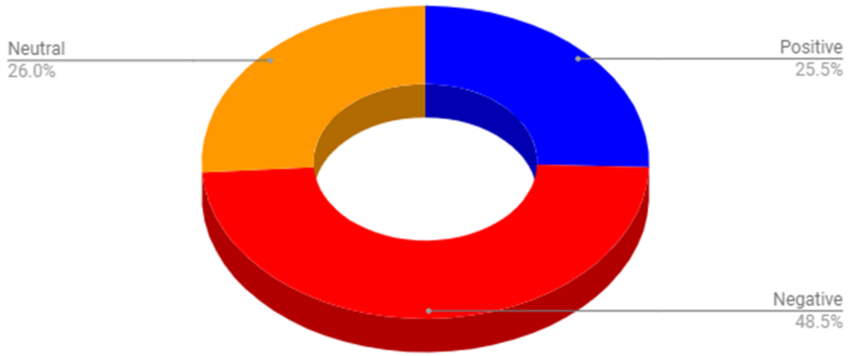
Year	Physical intervention	Rapid tranquilisation
2012	52	36
2013	57	45
2014	59	44
2015	64	18
2016	3	0
2017	4	0
2018	5	1
2019	1	1
2020	0	0
2021	0	0
2022	0	0

DIFFERENCE BETWEEN ADMISSION AND DISCHARGE

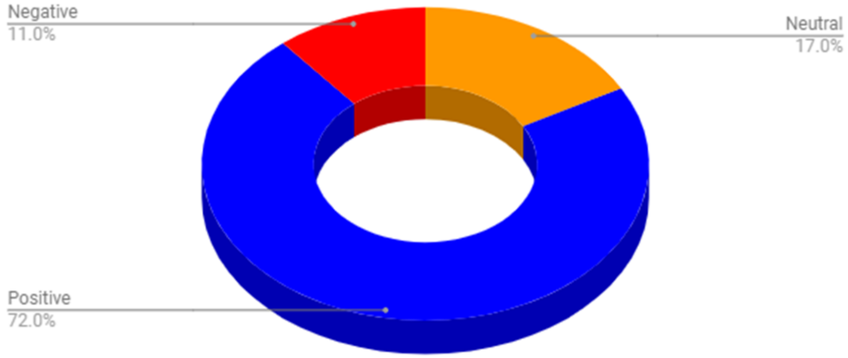


PATIENT EXPERIENCE

Old model survey comments (n = 198)



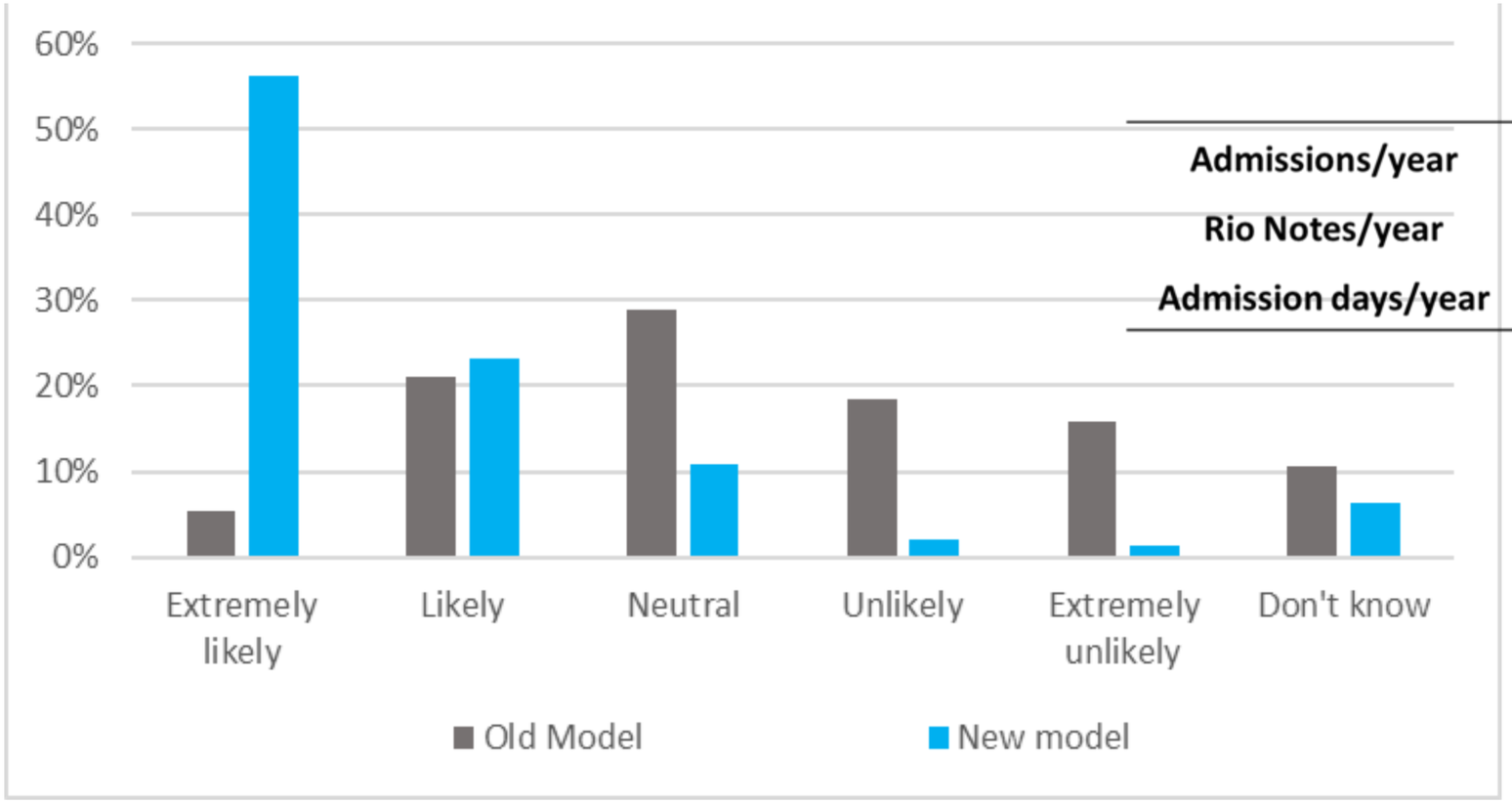
New model survey comments (n = 200)



PATIENT EXPERIENCE

Increased patient satisfaction and service use reduction

"Would you recommend this service to friends and family?"



	Before	After	Change
Admissions/year	5.4	0.5	-90%
Rio Notes/year	292	109	-59%
Admission days/year	41.0	1.9	-95%

STAFF'S EXPERIENCE

Increased job satisfaction

Richer therapeutic relationships

Better reputation

- Less vacancies
- Stable team
- Students!

WARD REPUTATION

RCPsych Awards 2019

Nominated for 'Team of the year'

BBC | BBC Account | News | Sport | Weather | iPlayer | Sounds | CBBC | CBeebi

NEWS

Home | UK | World | Business | Politics | Tech | Science | Health | Family & Education

Health

'How my life turned around with new treatment'

13 March 2019 Share

Patients at Fulbourn Hospital surrounded by the staff who have helped them

"As a child I was restrained, stripped and left in a room for three days," says

HSJ AWARDS 2020 Partnered with AGRI | WINNERS 2020 | PROJECT SHOWCASE 2020 | JUDGING | PARTNERSHIP | ALUMNI | CONTACT US | KEEP ME UPDATED

Patient Safety Award

Winner: Cambridgeshire and Peterborough FT - Abolishing restrictive interventions at Springbank Ward, specialist personality disorder unit

https://awards.hsj.co.uk/winners-2020

HSJ AWARDS 2020 Partnered with AGRI

CELEBRATING 40 YEARS OF HEALTHCARE EXCELLENCE

WE ARE PROUD WINNERS

Patient Safety Award

BIGSPD AWARDS

WINNERS 2020

Congratulations to all our award winners !!!

Outstanding Contribution Award - Kath Lovell

Early Career Researcher Award - Kimberley Webb

Innovation Award - Springbank Ward

PUBLICATIONS

› Psychiatr Danub. 2019 Sep;31(Suppl 3):626-631.

Attitudes towards a borderline personality disorder unit – a small-scale qualitative survey

Jakub Nagrodzki [1], Jorge Zimbron

Affiliations + expand

PMID: 31488804

Rethinking Risk Assessments in a Borderline Personality Disorder Unit: Patient and Staff Perspectives

Owen A. Crawford [1, 2], Tahir S. Khan [1, 2], Jorge Zimbron [1]

1. Springbank Ward, Fulbourn Hospital, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge, GBR 2. School of Clinical Medicine, University of Cambridge, Cambridge, GBR

Corresponding author: Owen A. Crawford, owen.crawford@outlook.com

Case Report

Treatment of Severe Emotionally Unstable Personality Disorder with Comorbid Ehlers-Danlos Syndrome and Functional Neurological Disorder in an Inpatient Setting: A Case for Specialist Units without Restrictive Interventions

Jessica Henry,[1] Eddie Collins,[2] Amanda Griffin,[3] and Jorge Zimbron[3]

[1]University of Cambridge School of Clinical Medicine, Addenbrooke's Hospital, Hills Rd, Cambridge CB2 0SP, UK
[2]Somerset Partnership NHS Foundation Trust, Bridgwater TA6 4RN, UK
[3]Springbank Ward, Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, Fulbourn, Cambridge CB21 5EF, UK

Correspondence should be addressed to Jessica Henry

Received 8 December 2020; Revised 16 February 2021; Accepted 18 February 2021

Academic Editor: Lut Tamam

Case Reports in Psychiatry
Article ID 6615723

Supplementary Materials

Case Report

Iatrogenic Complications of Compulsory Treatment in a Patient Presenting with an Emotionally Unstable Personality Disorder and Self-Harm

Charlotte Burrin,[1,2] Natasha Faye Daniels,[1,3] Rudolf N. Cardinal,[4,5] Catherine Hayhurst,[6] David Christmas,[4] and Jorge Zimbron[4]

[1]University of Cambridge School of Clinical Medicine, Cambridge, UK
[2]King's College, Cambridge, UK
[3]Hughes Hall, Cambridge, UK
[4]Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Cambridge, UK
[5]Department of Psychiatry, University of Cambridge, UK
[6]Emergency Department, Addenbrooke's Hospital, Cambridge, UK

Correspondence should be addressed to Jorge Zimbron

Received 23 October 2020; Revised 26 April 2021; Accepted 3 May 2021

INSIGHTS

Constant reflection about own behaviour

Co-production an constant change

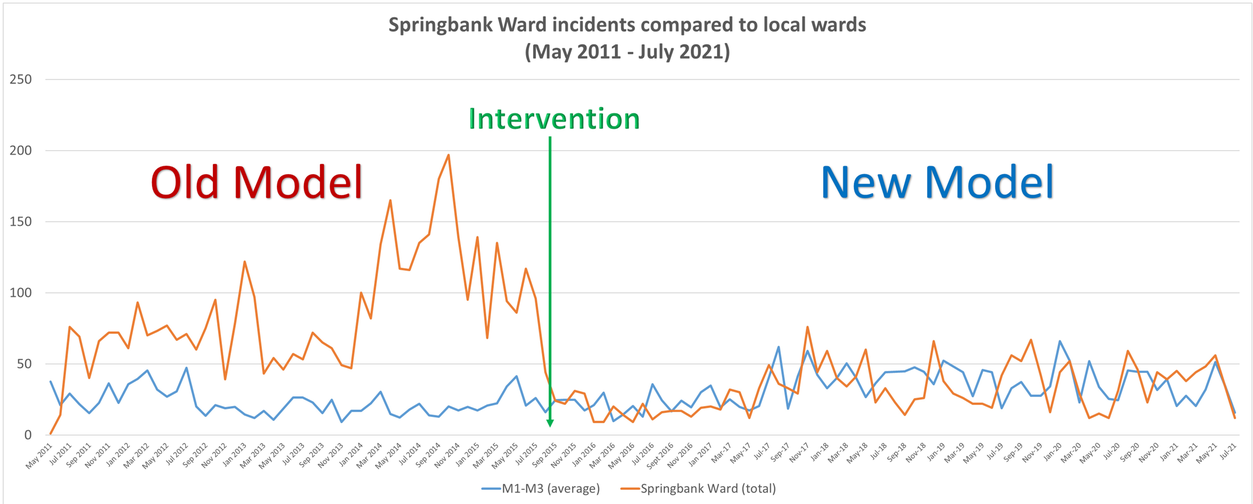
Multi-disciplinary approach as a community

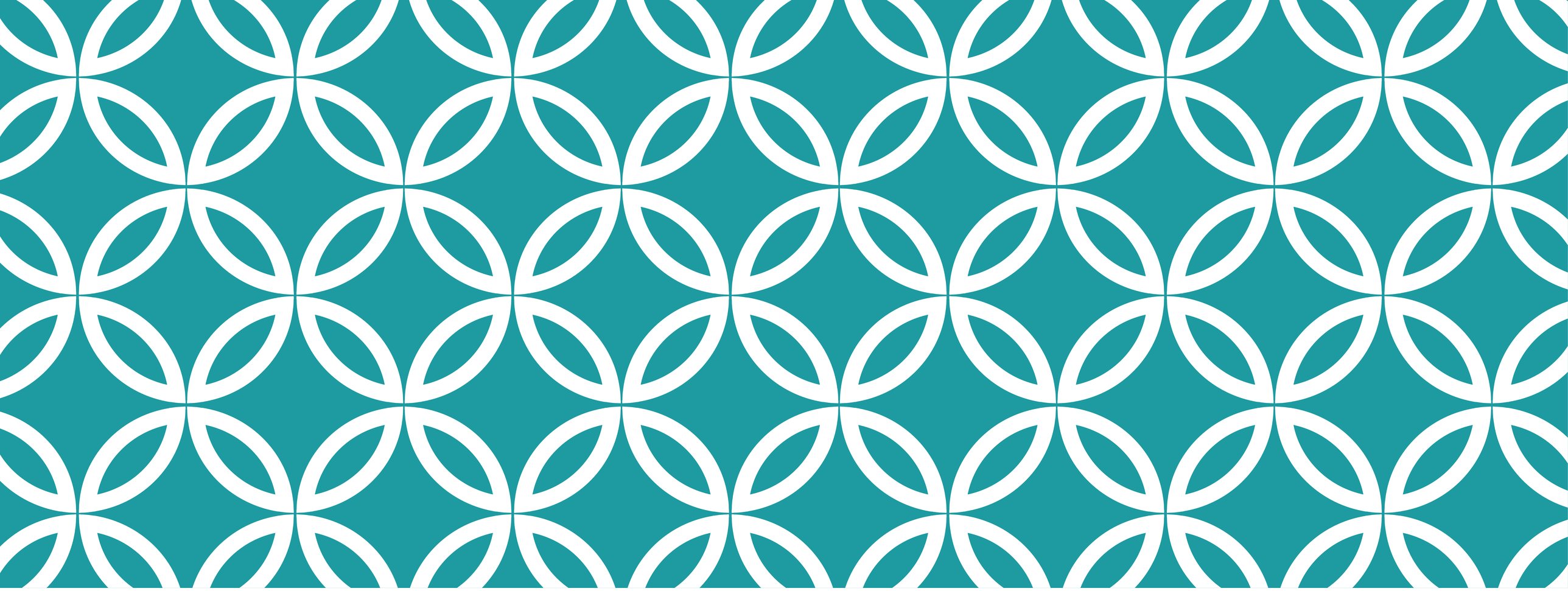
Values and clear boundaries

- Not rules

Courage, empathy, and compassion

- Safer than risk containment





SPRINGBANK PARALLELS

INPATIENT TRIALS

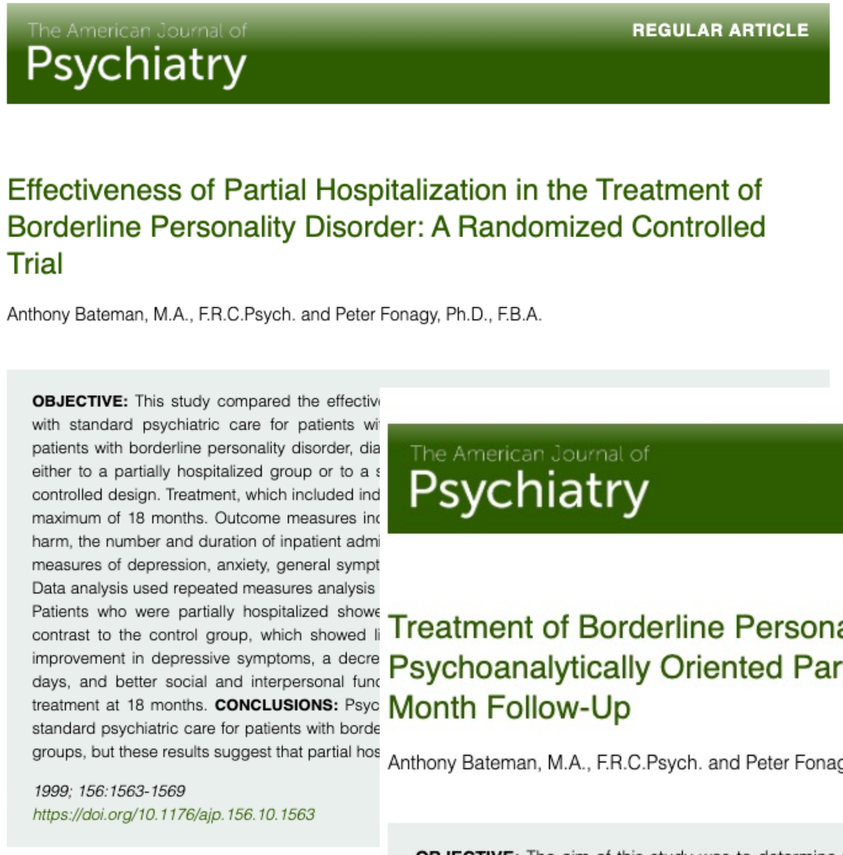
RCT 1999

- Partial hospitalization vs TAU
- N=38

18m programme

Improvements in symptoms, self-harm, suicide attempts, inpatient days, functio in inpatient group.

Ongoing improvement after 18m



The American Journal of Psychiatry

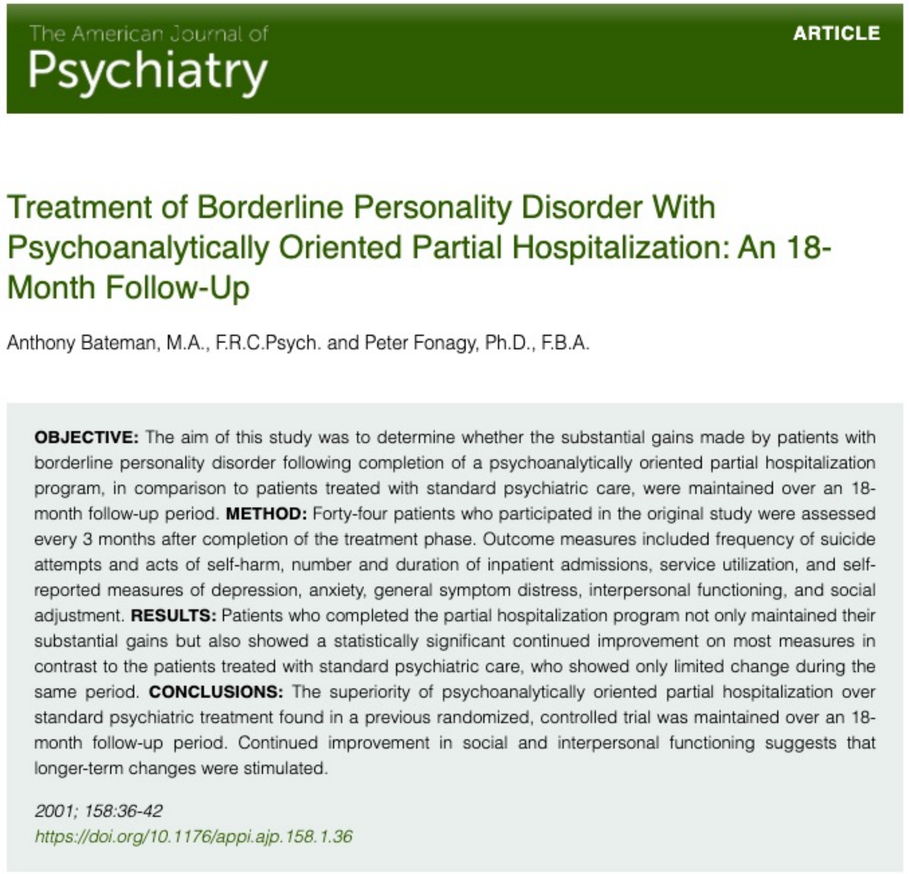
REGULAR ARTICLE

Effectiveness of Partial Hospitalization in the Treatment of Borderline Personality Disorder: A Randomized Controlled Trial

Anthony Bateman, M.A., F.R.C.Psych. and Peter Fonagy, Ph.D., F.B.A.

OBJECTIVE: This study compared the effectiv
with standard psychiatric care for patients wi
patients with borderline personality disorder, dia
either to a partially hospitalized group or to a s
controlled design. Treatment, which included ind
maximum of 18 months. Outcome measures inc
harm, the number and duration of inpatient admi
measures of depression, anxiety, general sympt
Data analysis used repeated measures analysis
Patients who were partially hospitalized showe
contrast to the control group, which showed li
improvement in depressive symptoms, a decre
days, and better social and interpersonal func
treatment at 18 months. **CONCLUSIONS:** Psyc
standard psychiatric care for patients with borde
groups, but these results suggest that partial hos

1999; 156:1563-1569
https://doi.org/10.1176/ajp.156.10.1563



The American Journal of Psychiatry

ARTICLE

Treatment of Borderline Personality Disorder With Psychoanalytically Oriented Partial Hospitalization: An 18-Month Follow-Up

Anthony Bateman, M.A., F.R.C.Psych. and Peter Fonagy, Ph.D., F.B.A.

OBJECTIVE: The aim of this study was to determine whether the substantial gains made by patients with borderline personality disorder following completion of a psychoanalytically oriented partial hospitalization program, in comparison to patients treated with standard psychiatric care, were maintained over an 18-month follow-up period. **METHOD:** Forty-four patients who participated in the original study were assessed every 3 months after completion of the treatment phase. Outcome measures included frequency of suicide attempts and acts of self-harm, number and duration of inpatient admissions, service utilization, and self-reported measures of depression, anxiety, general symptom distress, interpersonal functioning, and social adjustment. **RESULTS:** Patients who completed the partial hospitalization program not only maintained their substantial gains but also showed a statistically significant continued improvement on most measures in contrast to the patients treated with standard psychiatric care, who showed only limited change during the same period. **CONCLUSIONS:** The superiority of psychoanalytically oriented partial hospitalization over standard psychiatric treatment found in a previous randomized, controlled trial was maintained over an 18-month follow-up period. Continued improvement in social and interpersonal functioning suggests that longer-term changes were stimulated.

2001; 158:36-42
https://doi.org/10.1176/appi.ajp.158.1.36

INPATIENT TRIALS

Controlled trial 2004

Inpatient DBT for 3 months vs waiting list

N=50 women

Significant improvements in symptoms, self-harm, and functioning in the inpatient group.

ELSEVIER

Behaviour Research and Therapy 42 (2004) 487–499

BEHAVIOUR RESEARCH AND THERAPY

www.elsevier.com/locate/brat

Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: a controlled trial

Martin Bohus [a,*], Brigitte Haaf [a], Timothy Simms [a], Matthias F. Limberger [a], Christian Schmahl [a], Christine Unckel [a], Klaus Lieb [a], Marsha M. Linehan [b]

[a] *Department of Psychiatry and Psychotherapy with Polyclinic, Albert-Ludwig-University of Freiburg, Medical School, Hauptstrasse 5, D-79104 Freiburg, Germany*

[b] *Department of Psychology, University of Washington, Seattle, WA, USA*

Received 15 November 2002; received in revised form 5 June 2003; accepted 11 June 2003

INPATIENT TRIALS

Case series

N=50

Inpatient DBT for 3 months

15m f/u

Improvements in psychopathology

Shorter communication

Effectiveness of dialectical behaviour therapy for borderline personality disorder in an inpatient setting

Christoph Kröger [a] [1] ✉, Ulrich Schweiger [b], Valerija Sipos [b], Ruediger Arnold [b], Kai G. Kahl [b], Tanja Schunert [b], Sebastian Rudolf [b], Hans Reinecker [c]

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https://doi.org/10.1016/j.brat.2005.08.012

Abstract

This study evaluates the effectiveness of dialectical behaviour therapy (DBT) for borderline personality disorder (BPD) in an unselected, comorbid population seeking 3-month inpatient treatment. We studied 50 consecutively admitted individuals (44 women, six men) with BPD as defined by DSM-IV at three time points (at admission, at discharge, and at the 15-month follow-up). For the clinical diagnoses, we used the Structured Clinical Interview for DSM-IV (SCID) and compared the frequencies of comorbid axis I and axis II disorders at admission and at the 15-month follow-up. Overall, participants showed a high degree of comorbidity. Psychopathology was significantly reduced at post-treatment and at follow-up. Effect sizes for outcome measures were within the range of those of previous studies. Our findings support the notion that the results of the DBT efficacy research can be generalized to an inpatient setting and to patients with BPD disorder with high comorbidity.

INPATIENT TRIALS

Case series

N=45

Day patient MBT for 18m

Improvements in psychopathology, functioning, service use, suicide attempts and self-harm.

Treatment Outcome of 18-Month, Day Hospital Mentalization-Based Treatment (MBT) in Patients with Severe Borderline Personality Disorder in the Netherlands

Dawn Bales, Nicole van Beek, Maaike Smits, Sten Willemsen, Jan J. V. Busschbach, Roel Verheul and Helene Andrea

Published Online: August 2012 • https://doi.org/10.1521/pedi.2012.26.4.568

PDF PDF PLUS Share Tools

Abstract

Psychoanalytically oriented day hospital therapy, later manualized and named mentalization-based treatment (MBT), has proven to be a (cost-) effective treatment for patients with severe borderline personality disorder and a high degree of psychiatric comorbidity (BPD) in the United Kingdom (UK). As to yet it has not been shown whether manualized day hospital MBT would yield similar results when conducted by an independent institute outside the UK. We investigated the applicability and treatment outcome of 18-month, manualized day hospital MBT in the Netherlands by means of a prospective cohort study with 45 Dutch patients with severe BPD and a high degree of comorbid Axis I and Axis II disorders. Outcomes were assessed each six months. Symptom distress, social and interpersonal functioning, and personality pathology and functioning all improved significantly, with effect sizes between 0.7 and 1.7. Suicide attempts, acts of self-harm, and care consumption were also significantly reduced. The results indicate that MBT can effectively be implemented in an independent treatment institute outside the UK. This study also supports the clinical effectiveness of manualized day hospital MBT in patients with severe BPD and a high degree of psychiatric comorbidity.

INPATIENT TRIALS

Case series

N=245 vs 220 (reference group)

40 days admission (average)

BPD improved at a similar rate than reference group

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research paper

A naturalistic longitudinal study of extended inpatient treatment for adults with borderline personality disorder: An examination of treatment response, remission and deterioration☆

J. Christopher Fowler[a,b,c,*], Joshua D. Clapp[d], Alok Madan[a,b,c], Jon G. Allen[b], B. Christopher Frueh[e], Peter Fonagy[b,f], John M. Oldham[b]

[a] The Menninger Clinic, 12301 Main Street, Houston, TX 77035, United States
[b] Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030, United States
[c] Houston Me
[d] University o
[e] University o
[f] University C

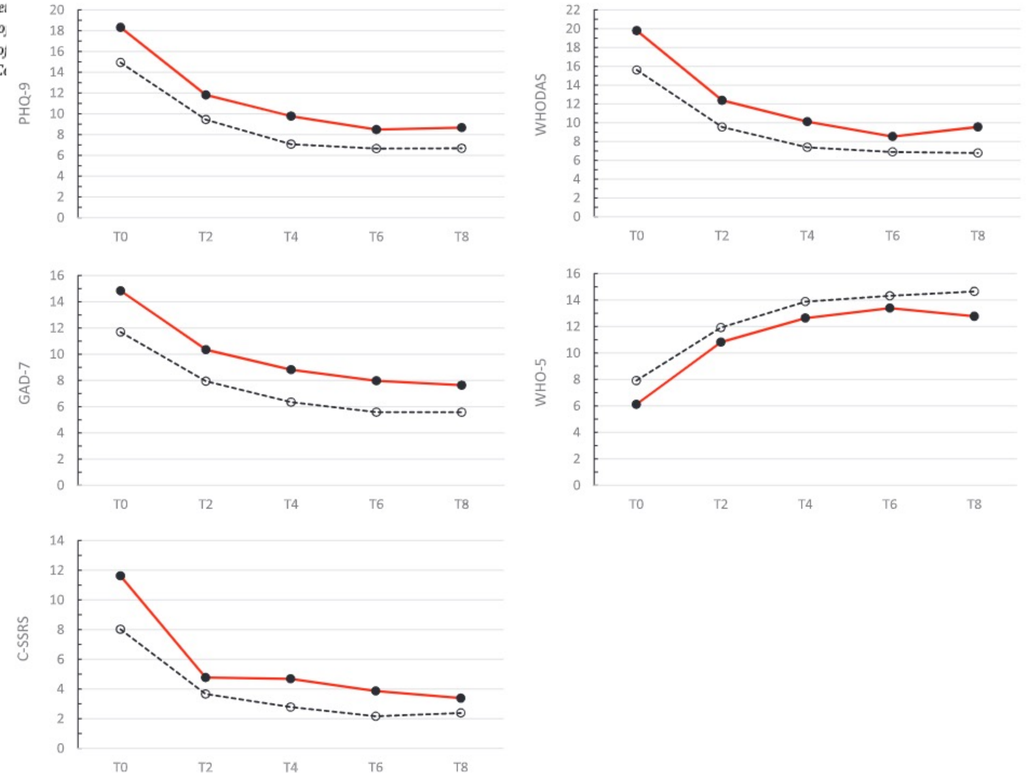


Fig. 1. Observed scores for reference and borderline personality disorder patients. (●——●) Borderline (○- - - - -○) Reference *Note*: PHQ-9 = Patient Health Questionnaire; GAD-7 = Generalized Anxiety Disorder 7-Item Scale; WHODAS = WHO Disability Assessment Schedule 2.0; WHO-5 = WHO Well-Being Index; C-SSRS = Columbia Suicide Severity Rating Scale – Ideation severity over the previous month.

SIMILARITIES

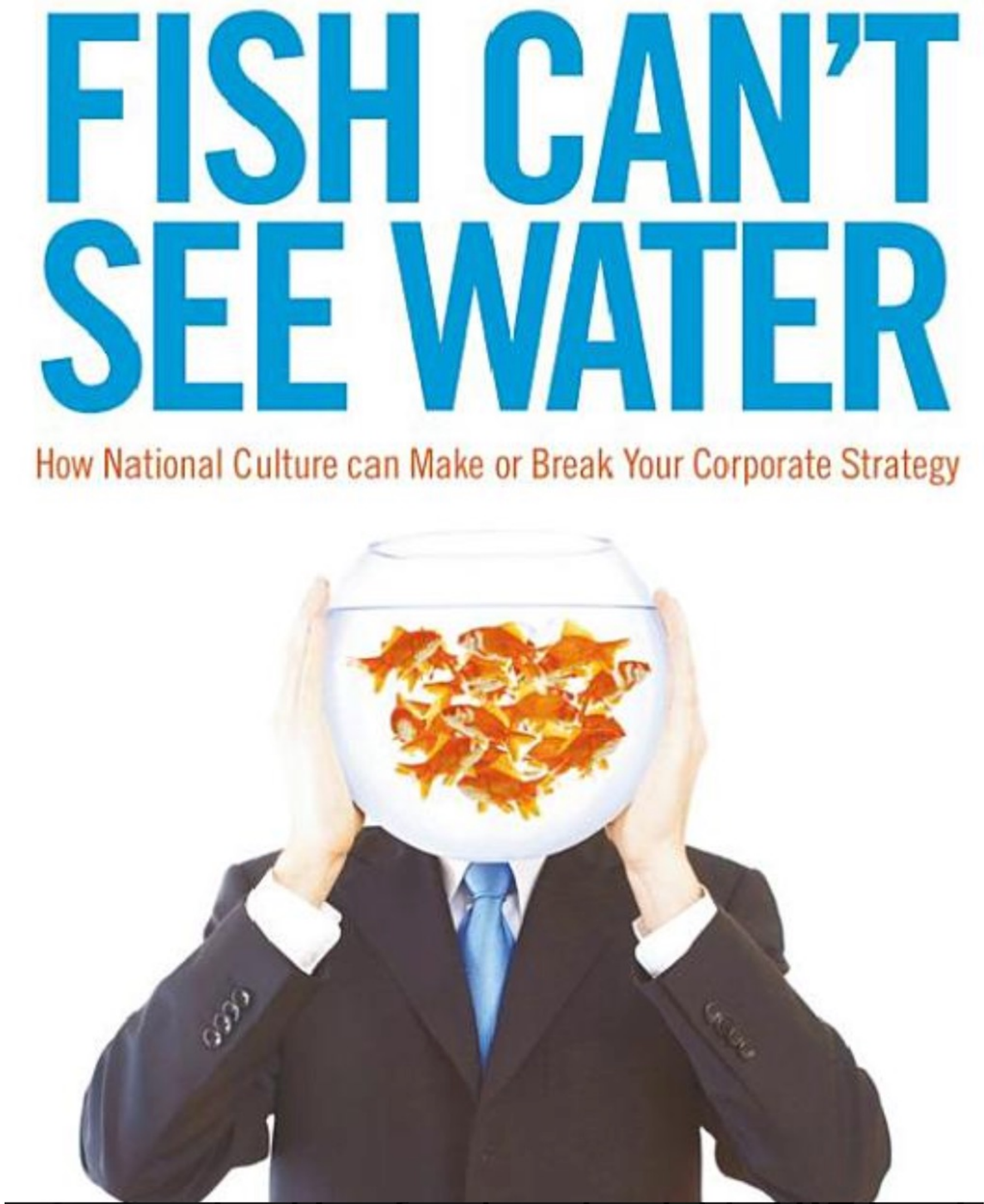
High degree of co-morbidity

Use of medication

Non-restrictive environment

No evidence of the use of coercive treatment being helpful.

AREAS TO IMPROVE



GUIDANCE

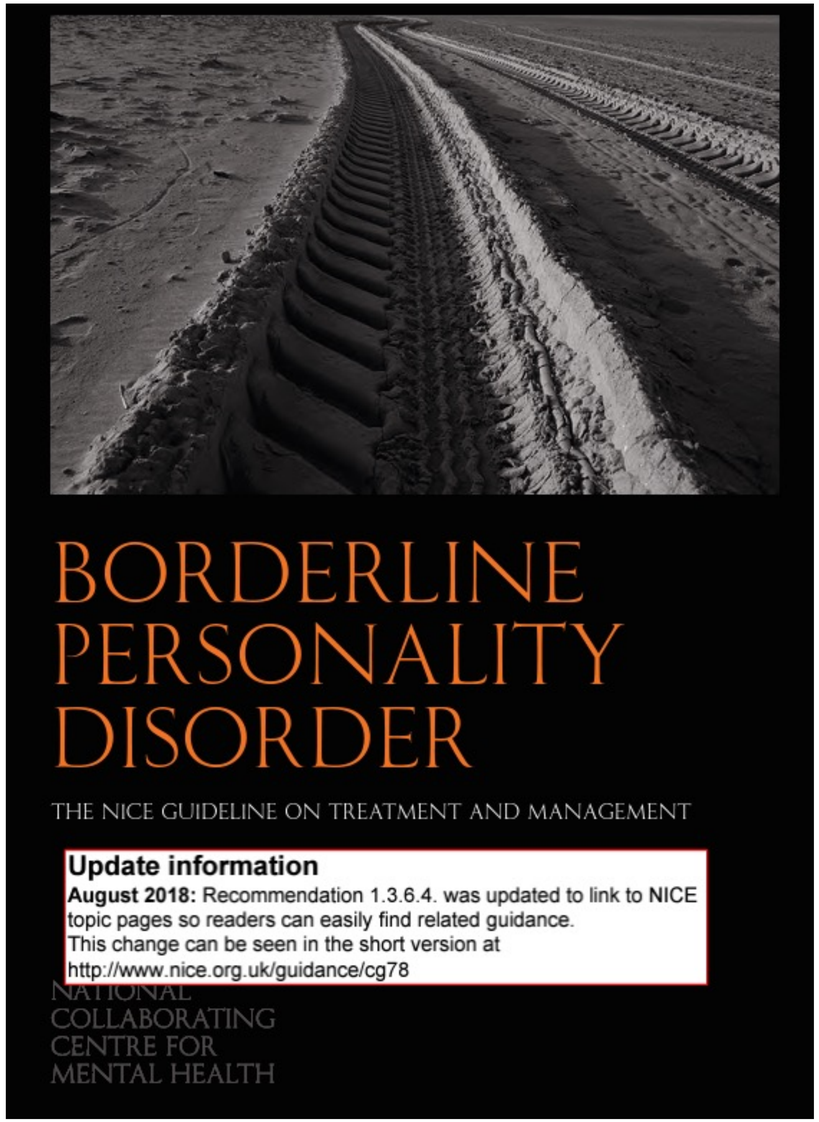
Acknowledge new evidence

- Benefits of specialist inpatient treatment
  - Skills
  - Environment
  - Relationships

Based on resources

Research

- Medication



MEDICATION


Cochrane Library

Trusted evidence.
Informed decisions.
Better health.

Title Abstract Ke

Cochrane Reviews | Trials | Clinical Answers | About | Help

Cochrane Database of Systematic Reviews

Pharmacological interventions for borderline personality disorder

Cochrane Systematic Review - Intervention | Version published: 16 June 2010 see what's new

https://doi.org/10.1002/14651858.CD005653.pub2

New search

Am score 27 Used in 4 guidelines View article information

Jutta Stoffers | Birgit A Völlm | Gerta Rücker | Antje Timmer | Nick Huband | Klaus Lieb

View authors' declarations of interest

Collapse all Expand all

Abstract

Available in English | Español | Français | 日本語

Cochrane 2010

1982 – 2009

28 RCTs

n = 1,742

Support:

- 2nd Gen Antipsychotics
- Mood stabilisers
- Omega 3

No support

- 1st Gen Antipsychotics
- Antidepressants

https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005653.pub2/full

COCHRANE CONCLUSIONS

Impulsivity
- Aripiprazole, lamotrigine, **topiramate**

Anger
- Haloperidol, aripiprazole, lamotrigine, valproate, **topiramate**

Psychotic symptoms
- Aripiprazole (not many tested)

Depression
- **Aripiprazole**, topiramate, amitriptyline

Anxiety
- Aripiprazole, **topiramate**

General pathology
- **Aripiprazole**, topiramate

Self-harm
- Nil (olanzapine worsens)

Poor results for emptiness, identity disturbance, abandonment.

THE SYSTEM

Acknowledge the problem

Design inpatient services for “personality disorder”

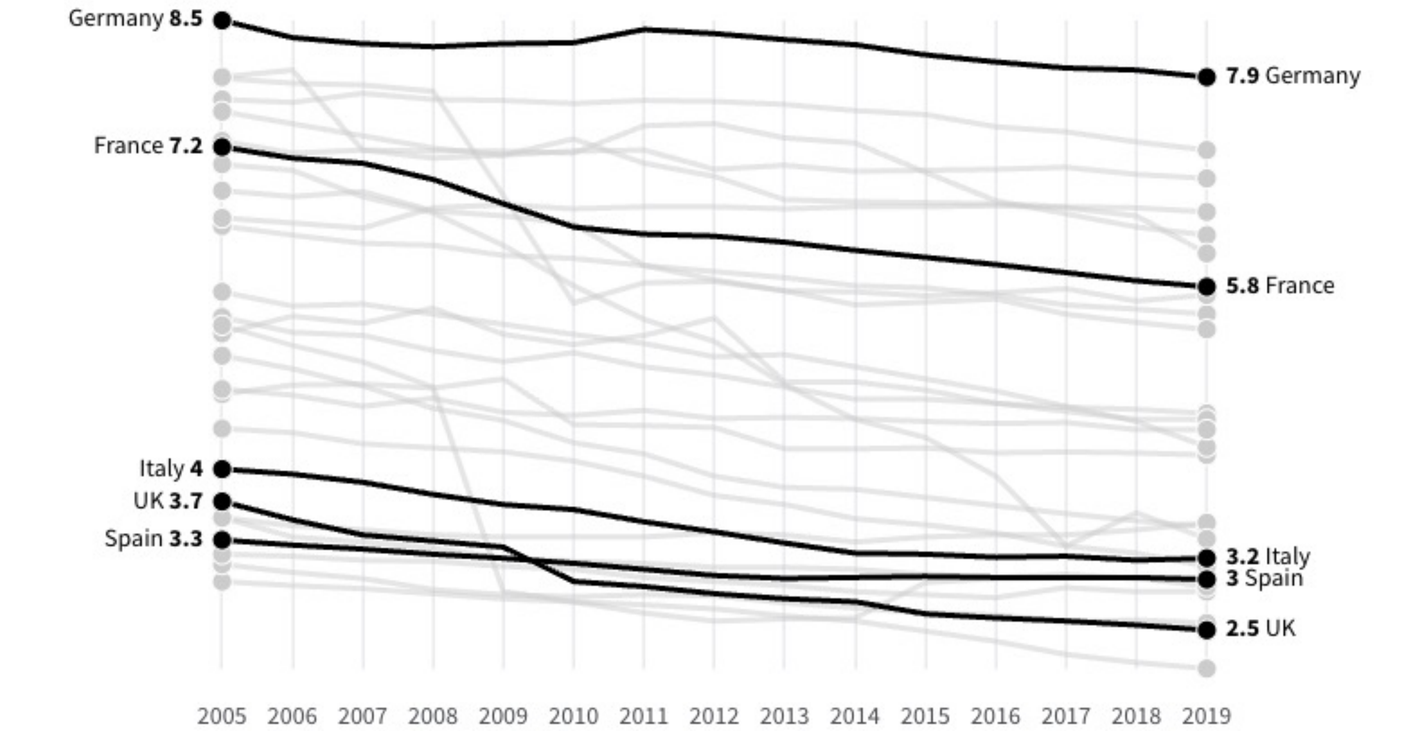
Develop specialist “PD” unit service specifications

Invest in the NHS

Monitor outcomes

Figure 6 The UK has fewer hospital beds than most comparable countries

Total hospital beds per 1,000 inhabitants



Source: Organisation for Economic Co-operation and Development (OECD)
Data is for 2019 or most recent year (2018 for United States). Total hospital beds includes curative care (or acute) beds, rehabilitative care beds, long-term care beds and other beds in hospitals.

The King's Fund

THE CULTURE

Stop restrictive interventions in personality disorder

- No evidence of benefit

Acknowledge fear and don't' give in

Train staff

Volume 2021 | Article ID 6615723 | https://doi.org/10.1155/2021/6615723

Show citation

Iatrogenic Complications of Compulsory Treatment in a Patient Presenting with an Emotionally Unstable Personality Disorder and Self-Harm

Charlotte Burrin,[1,2] Natasha Faye Daniels,[1,3] Rudolf N. Cardinal,[4,5] Catherine Hayhurst,[6] David Christmas,[4] and **Jorge Zimbron**[4]

Show more

Academic Editor: Toshiya Inada

Received	Revised	Accepted	Published
23 Oct 2020	26 Apr 2021	03 May 2021	27 May 2021

Abstract

Attempted suicide and deliberate self-harm are common and challenging presentations in the emergency department. A proportion of these patients refuse interventions and this presents the clinical, legal, and ethical dilemma as to whether treatment should be provided against their will. Multiple factors influence this decision. It is difficult to foresee the multitude and magnitude of complications that can arise once it has been decided to treat individuals who do not consent. This case illustrates a particularly

HELPFUL FACTS & TIPS

MYTH: RISK PREDICTION

We cannot predict risk at an individual level

For every completed suicide there are 200 attempts.

March 13, 2019

Prediction Models for Suicide Attempts and Deaths

A Systematic Review and Simulation

Bradley E. Belsher, PhD[1,2]; Derek J. Smolenski, PhD, MPH[1]; Larry D. Pruitt, PhD[1]; et al

» Author Affiliations

JAMA Psychiatry. 2019;76(6):642-651. doi:10.1001/jamapsychiatry.2019.0174

Key Points

Question Have advances in statistical modeling improved the predictive validity of suicide prediction algorithms sufficiently to render their predictions actionable?

Findings In this systematic review of 17 studies including 64 unique suicide prediction models, the models had good overall classification and low positive predictive values. Use of these models would result in high false-positive rates and considerable false-negative rates if implemented in isolation.

Meaning At present, the performance of suicide prediction models suggests that they offer limited practical utility in predicting suicide mortality.

PREVALENCE

Volume 213, Issue 6 December 2018 , pp. 709-715

Cited b

Acc

Prevalence of personality disorders in the general adult population in Western countries: systematic review and meta-analysis

Jana Volkert [a1], Thorsten-Christian Gablonski [a2] and Sven Rabung [a3]

DOI: https://doi.org/10.1192/bjp.2018.202 Published online by Cambridge University Press: 28 September 2018

Abstract

Background

Personality disorder is a severe health issue. However, the epidemiology of personality disorders is insufficiently described and surveys report very heterogeneous rates.

Aims

We aimed to conduct a meta-analysis on the prevalence of personality disorders in adult populations and examine potential moderators that affect heterogeneity.

Method

We searched PsycINFO, PSYNDEX and Medline for studies that used standardised diagnostics (DSM-IV/-5, ICD-10) to report prevalence rates of personality disorders in community populations in Western countries. Prevalence rates were extracted and aggregated by random-effects models. Meta-regression and sensitivity analyses were performed and publication bias was assessed.

Results

The final sample comprised ten studies, with a total of 113 998 individuals. Prevalence rates were fairly high for any personality disorder (12.16%; 95% CI, 8.01–17.02%) and similarly high for DSM Clusters A, B and C, between 5.53 (95% CI, 3.20–8.43%) and 7.23% (95% CI, 2.37–14.42%). Prevalence was highest for obsessive–compulsive personality disorder (4.32%; 95% CI, 2.16–7.16%) and lowest for dependent personality disorder (0.78%; 95% CI, 0.37–1.32%). A low prevalence was significantly associated with expert-rated assessment (versus self-rated) and reporting of descriptive statistics for antisocial personality disorder.

Conclusions

Epidemiological studies on personality disorders in community samples are rare, whereas prevalence rates are fairly high and vary substantially depending on samples and methods. Future studies investigating the epidemiology of personality disorders based on the DSM-5 and ICD-11 and models of personality functioning and traits are needed, and efficient treatment should be a priority for healthcare systems to reduce disease burden.

Declaration of interest

None.

PROGNOSIS

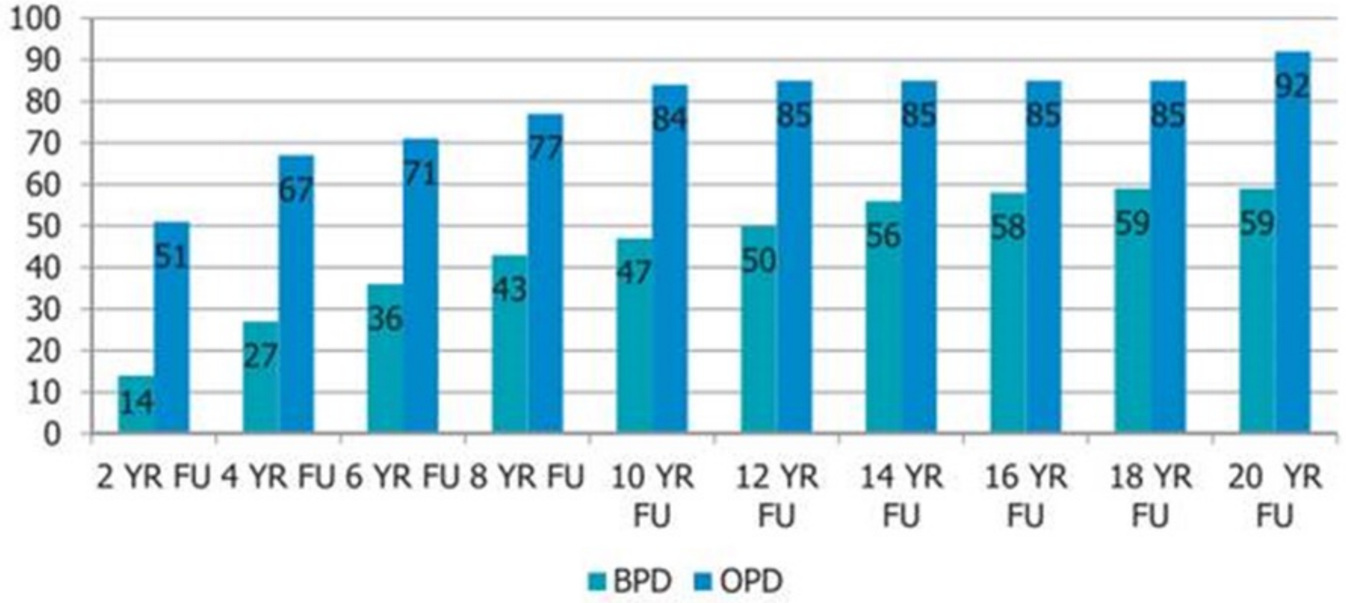


Fig. 1. Cumulative rates of good recovery over 20 years.

"Good recovery" is defined as global assessment of functioning above 61, minimal symptoms, and the ability to work, study and have meaningful relationships.

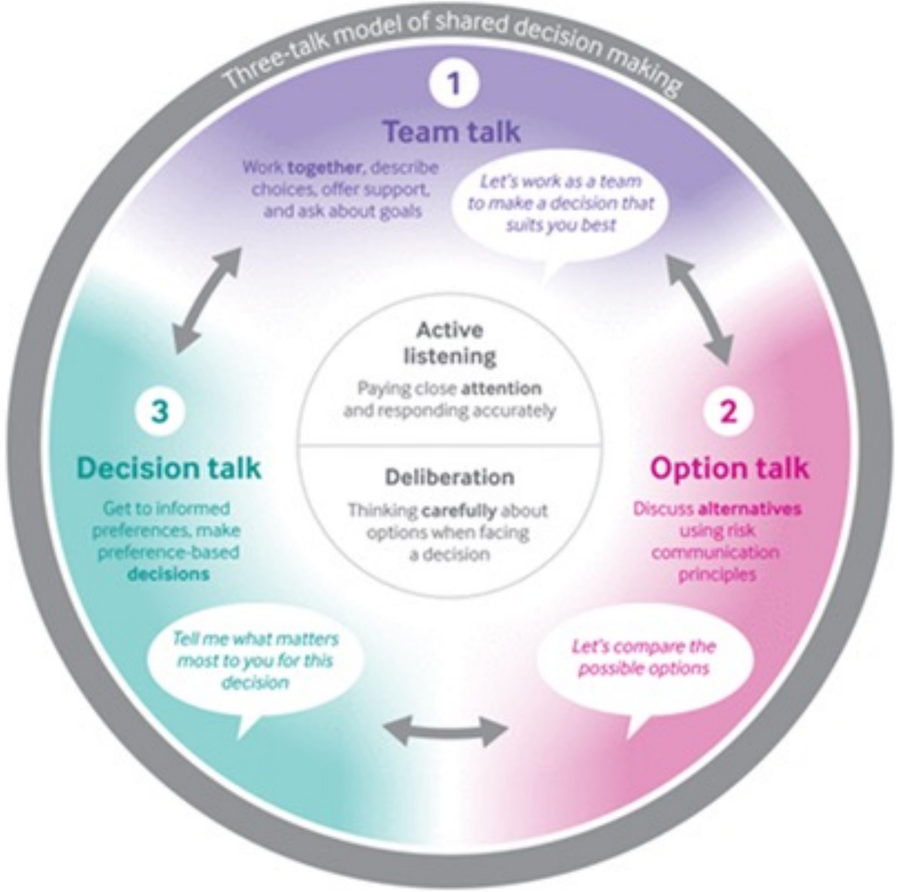
Zanarini, Mary C., Christina M. Temes, Frances R. Frankenburg, D. Bradford Reich, and Garrett M. Fitzmaurice. 'Description and Prediction of Time-to-Attainment of Excellent Recovery for Borderline Patients Followed Prospectively for 20 Years'. *Psychiatry Research* 262 (2018): 40–45. https://doi.org/10.1016/j.psychres.2018.01.034.

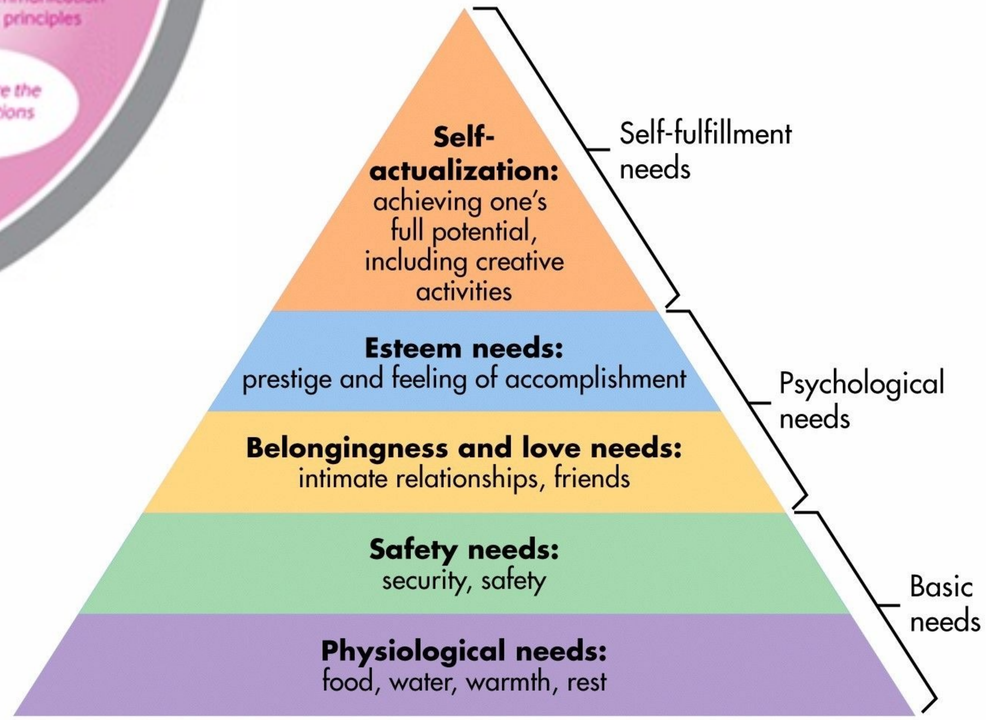
3 THINGS TO DO

Listen
- Build Trust

Contain
- Belongingness

Teach
- What would you do?





3 THINGS THAT HELP

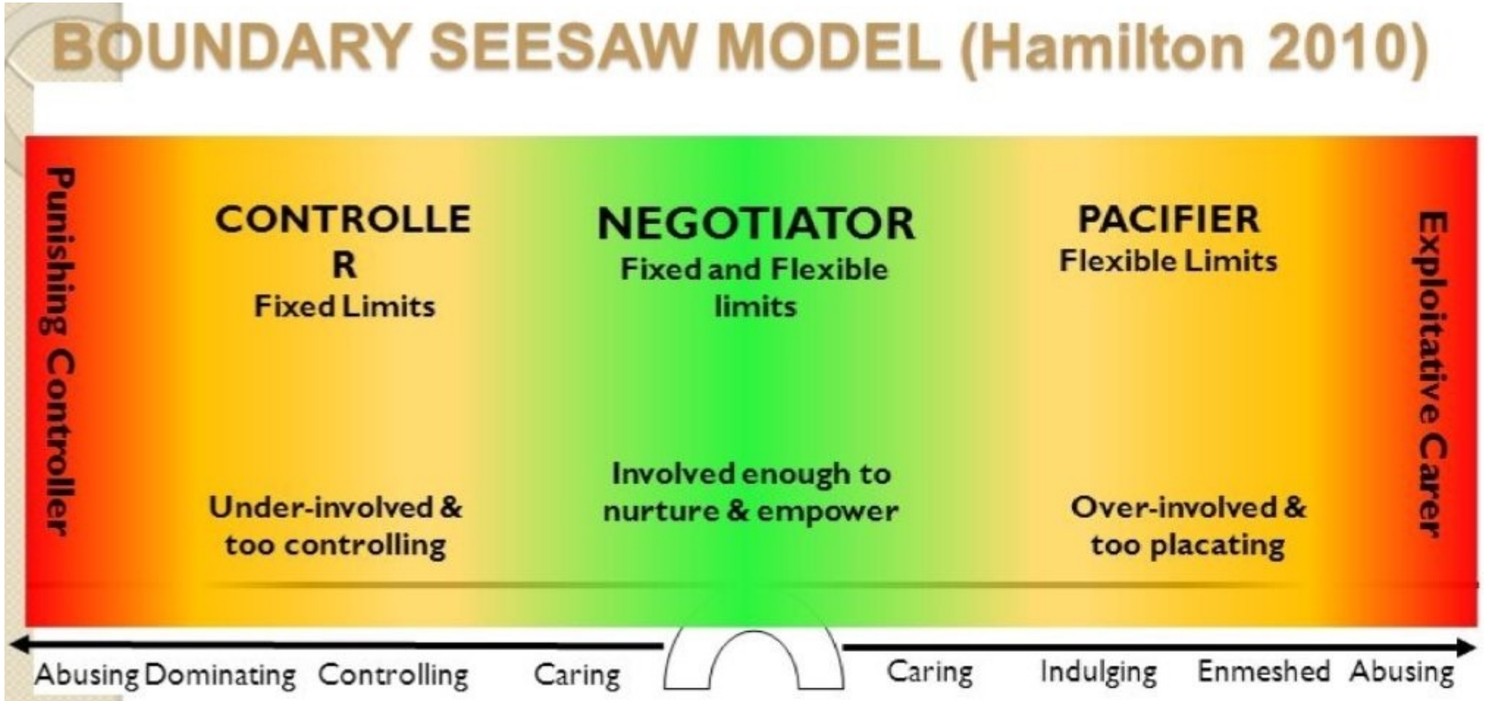
Boundaries

- Sustainable care

Reflection

- Mindfulness
  - Feelings
  - Environment

Your colleagues



Hamilton, L (2010). Boundary Seesaw Model: Good fences make for good neighbours. In Tennant, A. & Howells, K. (Eds.), *Using Time, Not Doing Time: Practitioner Perspectives on Personality Disorder & Risk* (p181-194). Chichester: Wiley-Blackwell.

QUESTIONS?