Personality Disorder
Integrated Care Pathway
(PD–ICP)

12: Inpatient Care

July 2015
Acknowledgements

This document was produced by a partnership of NHS Highland staff, volunteers, service users and staff from other public and third sector organisations.

The NHS Highland Personality Disorder Service will coordinate future reviews and updates of this document.

NHS Highland would like to thank everyone involved in the creation of this document.

July 2015
12. Inpatient Treatment

12.1 An overview of the evidence

Best available evidence suggests that, on the whole, acute in-patient care is at best neutral and at worst damaging to the long term recovery of people with personality disorder. However, there will of course be occasions when inpatient care can be life-saving in the short term if used judiciously.

Long term specialist residential placements also fail to show positive long term benefits. This suggests that the problem is not due to a lack of specialist skills, knowledge or attitudes within acute ward staff.

One study showed that a short stay in a specialist residential unit followed by long term outpatient treatment had significantly better outcomes in a variety of indicators than long stay specialist residential treatment.

Severity of personality disorder also appears to be a negative predictor of outcome for inpatient treatment, but this does not seem to be the case for outpatient treatment.

There appears to a principle of “less is more” as regards inpatient treatment. The benefit of “less” may be explained by the incremental accrual of skills by managing emotional crises in the everyday interpersonal and social contexts in which they arise. This contrasts with a pattern of avoiding such situations by admission to hospital, which inhibits in vivo skills development. Admitting a dysregulated, emotionally sensitive individual to a highly emotionally-charged environment, where staff may have different views on the appropriateness of the admission and respond differently to the patient as a result, can have significant dysregulating effects. Many people with borderline personality disorder are likely to be particularly sensitive to real or perceived disapproval from staff and/or other patients. This increased emotional sensitivity, and sensitivity to rejection in particular, can lead to an emotional response of intolerable intensity. Very often, the only strategies available to the patient to modify such unpleasant emotional states are unhelpful, for example self-harm, use of drugs or alcohol etc. Use of such strategies in the inpatient setting is often viewed negatively by staff, and any disapproval or even gentle challenging of the behaviour may be experienced by the patient as a rejection, leading to a further intolerable emotional response, which in turn may lead to more unhelpful behaviour in an attempt to feel better, with further challenges by staff, and so on.

12.2 When to consider admission

For these reasons, careful consideration should be given to alternative services capable of meeting the person’s needs. However, there may be occasions where in-patient admission is the most appropriate course of action. A description of circumstances when admission should be considered should be detailed in the care plan where possible. Care plans should be available in the case notes. Copies of Care Programme Approach plans are also held in the Assessment Suite at New Craigs Hospital.

Situations where consideration may be given to admission when all other options have been explored and deemed less appropriate include:

- Management of an acute increase in suicide risk (as opposed to chronic suicide risk which is unlikely to be improved, and may be increased by admission) or other extremely
risky behaviour. Important factors to consider are an acute increase in suicidal intent or impulsivity. Tools such as STORM can be useful in identifying an acute increase on chronic baseline risk.

- Changes to medication which cannot be managed in the community. This may involve rationalisation of polypharmacy more rapidly than could be done as an outpatient.
- Intensive assessment which cannot be carried out in the community. This may include clarification of diagnosis. Personality disorder can occasionally present similarly to axis 1 disorders but treatment approaches are usually significantly different.
- Treatment of co-occurring severe mental state disorders.

The short and long term potential benefits of admission should be weighed against the short and long term risks of harm and discussed with the patient. Consideration of admission to hospital must be balanced against the evidence that admission to hospital (especially lengthy admission) may be harmful for many patients with borderline personality disorder, in terms of extending the duration of the disorder and acute symptomatic deterioration.

Any existing care plans, for example CPA care plans, should be considered in the decision-making process.

12.3 During admission

If it is considered that admission to hospital is unavoidable:

- The phase of treatment should be identified and indicated to everyone involved. Hospital admission is likely to be of benefit in safety and containment (Phase 1a and 1b) but is likely to be detrimental to the development of self-regulation and control (Phase 1c). This may help to explain why meaningful stabilisation is uncommon during extended hospital admission.
- Admission should be kept as short as possible, with the timescale agreed and documented at the point of admission. Most acute behavioural dysregulation recedes within 24-72 hours. This provides a timeframe for discharge to community treatment and a clear rationale should be documented for admissions which exceed this duration given that it seems very likely that the risk of harm increases with the length of admission.
- Clear objectives and purpose for the admission should be agreed and documented at the outset. At the time of admission the aims of admission should be agreed with the patient and documented along with the reasons why other options were considered and rejected.
- Roles and responsibilities of staff and patients should be clearly explained and agreed, with contingencies of treatment frame explicitly explained. For example, it may be explained to the patient that non-engagement with the agreed treatment plan may lead to a review of the usefulness of continuing the admission. The treatment plan may include components such as an expectation that the patient takes responsibility to problem solve any factors contributing to an acute crisis, that they undertake not to self-harm while in hospital, that an attempt is made to enhance and use self-regulatory skills.
- An admission may be viewed as an opportunity to review care plans, crisis plans and goals, and successfully re-establish outpatient treatment.
- An admission may be an opportunity to refer for a phase-appropriate treatment.
• Avoid inappropriate use of medication, especially benzodiazepines and similar sedatives.
• During admission contact should be maintained with the person’s key worker in Community Mental Health Services.
• Crisis admissions should aim to (in line with standard crisis resolution approaches):
  • Stabilise the acute crisis rather than tackle the underlying disorder. The aim is a return to pre-crisis functioning and rapid discharge.
  • Re-establish care plan and crisis plan
  • Address changeable stressors
  • Reduce access to means of suicide
  • Identify and mobilise current supports

The Crisis Admission Document may be helpful in supporting the patient and care team to keep the admission focused and time-limited.

12.4 Discharge and transitions

Effective discharge planning should begin as soon as possible from the time of admission and should involve the multi-agency and multi-disciplinary team, the patient and where appropriate a significant social network member. The discharge process should be a seamless process, ensuring that appropriate services are available for the patient. Discharge and/or transfer care plans need to be well coordinated, based on the individual’s assessed needs, reviewed regularly, and include ongoing risk assessment and management. This can only be done with effective planning and communication.

Consider Care Programme Approach (CPA) for individuals with frequent readmissions, with clarity in the care plan about benefit and/or harm associated with hospital admission and a clear alternative community plan.

12.5 Mental Health Act

Although personality disorder is one of the three listed types of mental disorder in terms of the Mental Health (Care and Treatment) (Scotland) Act 2003, there is expert consensus that compulsory treatment should be used only in the most extreme circumstances and management on a voluntary basis should be resumed as soon as possible.

Compulsory treatment essentially removes personal responsibility for self-management from the patient. Assumption of responsibility by the patient for their own recovery is a fundamental principle in the treatment of personality disorder. Therefore, for most people with personality disorder, detention to hospital represents management rather than treatment.

The five criteria for making the three forms of detention under the MH(S)A are similar:
  • Emergency Detention Certificate criteria state that the medical practitioner considers it likely that:
    • the patient has a mental disorder;
    • and because of that mental disorder, the patient’s decision-making ability with regard to treatment for that mental disorder is significantly impaired;
    • The practitioner must also be satisfied that:
      • it is necessary as a matter of urgency to detain the patient in hospital in order to
determine what medical treatment should be provided to the patient for the suspected mental disorder;

- there would be significant risk to the health safety or welfare of the patient or to the safety of another person if the patient was not detained in hospital;
- making arrangements with a view to granting a short-term detention certificate would involve undesirable delay.

**Short-term Detention Certificate** criteria state that the medical practitioner considers it likely that:

- the patient has a mental disorder;
- because of the mental disorder, the patient’s ability to make decisions about the provision of medical treatment is significantly impaired;
- it is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the patient;
- if the patient was not detained in hospital there would be significant risk to the health, safety or welfare of the patient or to the safety of another person;
- the granting of the short-term detention certificate is necessary.

**Compulsory Treatment Order** criteria which the tribunal must be satisfied are fulfilled:

- that the patient has a mental disorder;
- that because of the mental disorder the patient’s ability to make decisions about the provision of medical treatment is significantly impaired;
- that medical treatment which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder is available for the patient;
- that if the patient was not provided with such medical treatment there would be a significant risk to the health, safety or welfare of the patient or to the safety of another person;
- that the making of a Compulsory Treatment Order in respect of the patient is necessary.

Points to consider for each criterion include:

**EDC,STDC,CTO: The patient has a mental disorder.**

- Personality disorder is one of the three broad categories of mental disorder in terms of the MH(S)A. The other 2 categories are mental illness and learning disability.

**EDC, STDC, CTO: Significantly impaired decision making ability(SIDMA):**

- Best available evidence indicates that hospital treatment is, on the whole, at best neutral and at worst harmful for people with personality disorder. Therefore it may be difficult to argue that SIDMA is present on the basis of a patient refusing hospital treatment alone.

- Best available evidence shows, on the whole, no significant benefit for drug treatment. Therefore it may be difficult to argue that SIDMA is
present on the basis of a patient refusing drug treatment alone.

- **EDC**: It is necessary as a matter of urgency to detain the patient in hospital in order to determine what medical treatment should be provided to the patient for the suspected mental disorder:

- **STDC**: it is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or giving medical treatment to the patient:

- **CTO**: that medical treatment which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms or effects of the disorder is available for the patient:

The treatment provided for an individual should be phase-appropriate. Most patients who are considered for detention will need treatments aimed at promoting safety (Phase 1a), containment (Phase 1b) or self-regulation and control (Phase 1c). Hospital treatment may be useful in promoting safety and containment but is likely to have a neutral or negative effect on self-regulation and control. Therefore, although hospital treatment may alleviate isolated symptoms, for example high intensity nursing care may physically prevent suicidal behaviour, it is unlikely that hospital treatment will prevent the disorder itself from worsening, and may be likely to contribute to a global deterioration. Clinical experience suggests that these factors are even more relevant when patients are detained than during informal admissions.

Several different models of psychological therapy have been shown to be effective in the treatment of personality disorder. All trials involved voluntary patients, and there is no evidence base for the treatment of involuntary patients. Furthermore, many of the treatment models expressly discourage use of compulsion for reasons of conflict with the general and specific factors and theoretical principles upon which the treatments are based.

- **EDC, STDC, CTO**: significant risk to the health, safety or welfare of the patient or to the safety of another person if not detained in hospital/ provided with medical treatment:

- As outlined above, while high intensity nursing care may promote safety by physically preventing suicidal behaviour and acutely lower the risk of suicide, hospitalisation and detention may actually increase chronic suicide risk and worsen prognosis.

- **STDC, CTO**: necessity:

- Consideration should be given to all other treatment options, especially those with an evidence base and those coherent with the general principles of the treatment of personality disorder. Often hospital treatment, especially under detention, amounts to conservative management of the disorder rather than positive treatment. There should be recognition that risk cannot be entirely eliminated whatever the course of treatment or management. Furthermore, positive, collaborative risk-taking based upon a position of compassion and firm clinical rationale often forms an indispensable component of the treatment of personality disorder.

### 12.6 Structured Admissions Program

This program was developed for patients with personality disorder who had multiple crisis
admissions. It allows patients and the treating team to schedule 4 one-week admissions in year 1, 3 one-week admissions in year two, 2 one-week admissions in year 3 and 1 one-week admission in year 4, provided crisis admissions are avoided. Each admission will have a specific goal or goals which will be worked towards using a CBT-type framework. These admissions are not used for other purposes, for example medication changes etc. The program is arranged by the user’s sector consultant psychiatrist. Continued contact with the Community Mental Health Services must be maintained and the person must have a named key-worker in the community.

Essentially the Structured Admissions Program is a team approach, with all the team members and the individual aiming towards an increase in structure, stability, confidence and independence.

The agenda for each admission will be discussed and agreed at a multidisciplinary meeting of the patient together with relevant community and hospital based clinicians at least 4 weeks before the admission.

Clinicians should be cautious of adapting this intervention without fully considering the behavioural contingencies and risk-benefit balance of any adaptation.

The Structured Admissions Program as originally conceived represents a Phase 1 intervention.

The evidence base for this intervention is comprised of non-experimental, descriptive evaluation. There should be a clear clinical rationale for considering this intervention over other Phase 1 interventions such as DBT or STEPPS with more robust evidence bases.

There is unlikely to be any added benefit in an individual engaging in both a psychological therapy like DBT and the Structured Admissions Program. In fact, there may be theoretical conflict. It is suggested that if a patient is on the Structured Admissions Program and is being considered for referral for DBT or STEPPS, that the case should be discussed with the appropriate service at the time of referral.
12.6.1 Specific features of the Structured Admissions Programme:

1. The individual wishing to have structured admissions should be made aware that they are an alternative to crisis admissions.

2. The number of structured admissions per year will be identified at the start of each year and will be linked to the care plan based upon individual need. The composition of the team should remain consistent across admissions, as far as possible.

3. The maximum number of structured admissions per year is four. The program can also commence with three structured admissions per year. The annual number of admissions reduces by one each year. Once the individual progresses to a single admission in a year, needs will be reassessed.

4. Though structured right from the start, these admissions do not happen automatically. Each admission will be on the merit and benefits of the previous one - how this has helped the individual cope with stress, how the coping strategies learnt have been made use of when in crisis etc.

5. There will be no medical input during admission except for technicalities of admission and discharge.

6. The focus is on de-stressing and learning ways to manage distress in the context in which it arises, rather than medicalising the issue.

7. If there are difficult dates or anniversaries, admissions can be planned around those dates. Planning needs to be done before structuring the admissions.

8. Intense Nursing, Occupational Therapy and Physiotherapy input will be provided as planned before each admission.

9. No other psychology/ psychotherapy session will be possible during the admission week, if some one is already in psychological treatment, the individual is expected to rearrange those sessions which occur during the period of admission. This should not prove problematic as structured admission weeks are known to the individual from the start of the year.

10. Structured admission is from Monday- Friday morning, no passes are usually allowed during this period. Patients are encouraged to keep visitors to a minimum during the admission period, as this can negatively impact upon the de-stressing process and contribute to valuable loss of time which could otherwise be spent working with the team.

11. Structured admission is from Monday- Friday morning, no passes are usually allowed during this period. Patients are encouraged to keep visitors to a minimum during the admission period, as this can negatively impact upon the de-stressing process and contribute to valuable loss of time which could otherwise be spent working with the team.

12. Individuals undertake not to engage in self harming behaviours, alcohol or drug use during admission. Such behaviours could lead to early discharge.

13. The individual is expected to take responsibility for their own treatment.
References


NICE. (2009). Borderline Personality Disorder Treatment and Management. NICE Clinical Guideline 78.