Challenges in the development of a unified clinical model and operational framework for inpatient Personality Disorder services

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Introduction

There can be little doubt that clinical and service interest in the provision of inpatient services for clients with personality difficulties is as prominent as it has ever been. It is arguable that there is increasing awareness of the importance of understanding the personality features of clients who present within the mental health and criminal justice arenas.

That said at the present time there does not appear to be universal consensus regarding how such inpatient services should best be delivered and/or managed. Nor indeed clarity as to the key features underpinning best practice in this arena. It appears to the authors that traditional approaches to the provision of clinical care for clients with personality disorder – such as Therapeutic Communities – have fallen out of favour; whilst in parallel treatment advances in this field have not necessarily been designed with the requirements of the inpatient setting in mind.

As a consequence it is the authors' contention that there are very few practice and service guidelines and directions to assist practitioners in their attempts to establish and deliver clinical services for their clients.

This paper utilises the experiences of two distinct specialists personality disorder services – one for female clients within a locked rehabilitation environment, the other a low secure service for male PD offenders to share and offer indication of their learning.

The Clinical Context

Diagnosis and Assessment

It is with some disappointment that the authors note the continuing difficulties in achieving a resolution regarding the establishment of a consensual diagnostic framework from which to identify client needs and circumstances and direct therapeutic interventions (Sarkar & Duggan, 2010).The evident difficulty arising within the DSM 5 committee is noted as is their compromise position of the 'traditional' approach offered within DIAGNOSTIC CRITERIA AND CODES in parallel with the hybrid model contained within Emerging Measures. As practitioners it is the authors view that such a position is inherently unsatisfactory and unhelpful.

In parallel the apparent approach adopted by ICD-11 which is understood to emphasise severity (including sub threshold identification) is seen by the authors as carrying significant potential within the clinical arena though clearly necessitating successful operationalisation of the degree of severity identified. Of particular concern is the potential for significant divergence of approach between the two systems.

Treatment

Without question it is reassuring to note that emerging evidence counteracts the historically significant pessimism that pervaded the field regarding the outcomes of treatment (Livesley, 2014). As Professor Livesley asserts evidence supports the therapeutic benefit of a range of interventions including:

- DBT (Linehan, 1993)
- TFT (Clarkin et al, 1999,2006)
- SFT (Young et al, 2003)
- MBT (Bateman & Fonagy, 2004)
- CBT (see Davidson, 2006)
- CAT (Ryle, 1997)
- STEPPS (Blum et al, 2008)
- Etc

Of particular concern however is that there appears little evidence of any differential efficacy of any of the specialised treatments over each other. Nor indeed more significant benefit that 'good clinical care or supportive therapy' (Livesley, 2014). Furthermore consideration of the components of difficulty open to change through such approaches highlight the emphasis on positive short term symptomatic improvement in contrast lack of positive improvement overall functioning appear common with core interpersonal problems and self identity difficulties perpetuating.

The Proposed Solution

In the context of the above it is the authors contention that a critical focus of any inpatient service should in addition to targeting immediate 'symptomatic' difficulties such as self harming behaviour and aggressive and antisocial conduct be the core interpersonal and identity dysfunctions that represent the person's personality difficulty. This we consider to be non-contentious as recognised in the deliberations of the DSM committee itself.

> The DSM-5 Personality and Personality Disorder Working Group accordingly proposed to define personality pathology in terms of "self" and "interpersonal" functioning (Skodol, 2012), and noted that "impairment in self and interpersonal functioning has been recognised by reviewers of the proposed DSM-5 model to be consistent with multiple theories of PD" (Bender et al., 2011, p341.)
>
> As the specific elements of these "substrates of personality psychopathology" (APA, 2012) involve how individuals think about themselves and others and how they relate to others, the proposal implies that the core features of personality pathology are **interpersonal**.
>
> Somewhat more explicitly, the DSM-5 website identified "social processes" (Sanislow et al., 2010) as the most relevant broad domain of research (**assessment and treatment**) for personality pathology.
>
> Hopwood, C, J, Wright, A, G, C, Ansell, E, B & Pincus, A, L (2013)

This can be most succinctly operationalised as:

Difficulty

- Achieving a coherent sense of self (interpersonal failure)
- Developing intimacy in interpersonal relationships (interpersonal failure)
- Behaving pro-socially (social group failure)

Practice Implications

Following this approach involves placing the therapeutic engagement of the team with the client at the centre of all that the service and its practitioners provides within the clinical environment.

- Main thrust of therapy is interpersonal management utilising formulation and reflective practice.
- Initial emphasis is containment in a safe environment where control is mainly external locus of control based on mainly procedural and structural security and some relational security. The ratio of security changes over a period of weeks to a more relational approach and less procedural and structural one, depending on engagement, risk issues etc. Rule – based approach is easier for new and less experienced staff.
- Second phase – social learning phase, key issues affecting social functioning are addressed, including risk issues.
- Features of personality disorder through individual, group and milieu modalities are addressed.
- Last stage – Resocialisation, where patients show demonstrable enhanced social functioning with evidence of reduced risk are facilitated to re-enter the society. Individuals are supported throughout this difficult process to make for social inclusion and integration.
- Could be through work skills, self support, independent living, pastoral care outside secure setting providing social opportunities etc.
- 'Ordinary' relationships and interactions are important not only to aid assessment and formulation, but also therapeutic.

This encompasses

Environmental Implications

- Living space is designed in a manner which optimises social interaction between both clients and clients and staff i.e. social areas at the heart of the layout
- In parallel the clinic area more generally emphasises collaboration – optimising spaces where staff and clients work together on tasks
- Building design and layout should minimise signals of control and hierarchy – blending staff areas with wider unit and 'toning down' overt security structures and organisational hierarchies

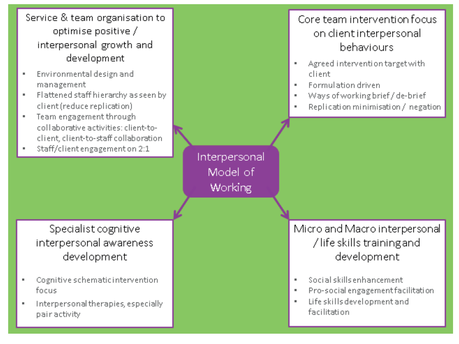
Organisational Implications

- Organisational policies and practice guidelines should serve to emphasise collaborative inclusive practice and minimise hierarchy-based differences
- The formal documentation regarding the client (e.g. CPA, Tribunal) should evidence the critical focus placed upon the individual's interpersonal functioning, and the collaborative approach taken by professional disciplines
- Systems of staff communication and 'handover' should provide the opportunity for reflective consideration of the emotional and interpersonal implications of working with the client. This should be integrated with the prepared formulatory analyses

Operational Implications

- Unit practice should evidence the formulatory based approach to working interpersonally with the client(s)
- The working week of the clients should evidence opportunity for involvement in critically identified processes including task groups and community meetings etc. This also evidencing client contribution to the management of their social space
- Routine practice should evidence the critical importance placed by the approach on communication. In the case of communication between
  - (a) staff and clients – this should reflect planned interactional sequences
  - (b) between staff – this should reflect appropriate use of de-briefing processes

Resulting in a holistic interpersonal approach



Evaluating the Outcomes

- Recognition of the range of domains of required outcome

Domains of Outcome Measures

Target Group	Significance/Applicability
1. Commissioners-oriented	1. Core Measures (generally applicable)
2. Clinicians-oriented	2. Cluster measures (service/patient specific)
3. Patient –oriented	
4. Organisational	

Clinical Domain

1. Diagnosis
2. Risk
3. Severity of personality pathology
4. Interpersonal functioning
5. Daily living skills
6. General psychiatric functioning (?)

Customer/ Commissioner Domain

- Length of stay
- Incidents (severity and frequency)
  - Deliberate self harm
  - Suicidal ideation/attempts
  - Aggression/violence to others
  - Absconding
  - Offense paralleling
  - Substance misuse
- Engagement levels
- Changes in restriction status
- Appropriate use of leave
- Improvement in daily living skills (independence)
- Discharge outcomes
- Relapse/readmission rate (longer term research)

How to define those indices?

What is considered baseline (what to compare)?

Service level vs individual patient level?

How much time to collect date?

Patient Domain

- Service Satisfaction
- Treatment with Respect
- Awareness of Choices
- Involvement in decision making
- Feeling Safe and Secure
- Service Responsiveness

Organisational Domain

- GAP
- HoNOS
- Lunsers
- DLSOS

Emerging Evidence

- Tentative indication of improvement in interpersonal functioning