Nurses take the lead in setting up an innovative service for people with personality disorder
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People with personality disorder were often seen as revolving door patients but a service has cut hospital stays, reduced medication and increased independence

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Abstract
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This article describes a novel community based service for personality disorder. Initially a pilot scheme in Oxfordshire, the success of this nurse led service has prompted other areas to set up similar programmes. Based on four tiers of therapeutic care, the service has substantial user involvement and aims to help people with personality disorder lead more fulfilling lives.

Keywords: Personality disorder, Community, Mental health, Nurse led

• This article has been double-blind peer reviewed.

Practice points
• The more autonomy we allow nurses, the more creative services can be developed and delivered.
• Nurses often have a diverse wealth of experience that can be harnessed to deliver new therapy opportunities for clients.
• Real involvement of current and former clients in every level of the service fosters a spirit of valuing, ownership and accountability. This principle equally applies to nurses and leads to high morale in teams, low staff turnover and exciting learning curves in personal development.
Introduction

Until recent years, personality disorder (PD) was deemed untreatable by orthodox psychiatry and many people were excluded from services – a belief that stems from poor quality studies (Dolan et al, 1997). The Oxfordshire Complex Needs Service (OCNS) was set up as a Department of Health pilot project to test an innovative approach to providing community personality disorder services. The ethos of the service is that people can recover and change the way they relate to themselves and others in order to lead more fulfilling lives.

People with personality disorder are likely to have had relationship and attachment difficulties which have begun early in life. These common interpersonal difficulties tend to be extreme and are probably in part adaptive responses to adverse early life events.

The prevalence for all personality disorders is generally accepted as 4.4%, or 5.7% if associated behavioural patterns of personality disorder are included (Coid et al, 2006). Yet one study on 303 UK primary care attendees found that as many as 24% of the sample had a diagnosable personality disorder (Moran et al, 2000).

The OCNS works with people in all 10 categories of the condition (see Background box) and commonly clients can be diagnosed with more than one disorder.

Setting up the service

Staff were recruited in 2004 with services gradually established over an 18 month period. It is now running at full capacity with 200 treatment places. The multidisciplinary team also offers advice, supervision and consultation. The service treats the most chaotic and disturbed clients with histories of severe abuse, deprivation, violence, high levels of self harm, suicidality and high use of services.

People with personality disorder had previously been “revolving door” patients, using inpatient psychiatric care, community teams, A&E departments and primary care, often with poor outcomes. The establishment of the OCNS offered choice and hope of recovery to people who were often rejected or excluded by services.


Role of nursing staff

Mental health nurses are at the core of the service, occupying seven of the 14 posts. Nursing leadership has evolved at all levels and is strongly encouraged and supported. The service values staff wellbeing, which has been instrumental in delivering tangible improvements in patient care and quality of life. Staff turnover and sickness levels are unusually low for mental health teams.

Nurses have changed, challenged and influenced the provision of community personality disorder services and the model is now being replicated in Wigan, Belfast and Milton Keynes.

Structure

The OCNS aims to help high users of services and those who are significantly disabled move out of mental health and other services and lead a more satisfying and less distressing life. Split into tiers,
it caters for people aged 18 and over and for those over 65 there is a dedicated group therapy programme. Participation is voluntary, and self referral is encouraged.

While there is no set criteria, in general the service is intended for those whom other services find difficult to help towards recovery, and whose problems have been long term and intractable.

**Tier 1 - engagement and consultation**

User involvement lies at the heart of the service. There is no waiting list for referrals and clients are engaged at tier 1 until they are ready to move on. The next step is offered when they decide to make significant changes to their situation. People who suffer from psychoses, learning difficulties, persistent cognitive deficits, or who are consistently unwilling to look at their own contribution to their problems and the possibility of change are less likely to benefit. For these groups discussion is recommended before referral.

Many people who meet the criteria for personality disorder have been misdiagnosed previously, commonly with depression or bipolar disorder, or have experienced multiple changing diagnoses. This is associated with multiple treatment plans often by several agencies at the same time, with lots of prescribed medication.

After assessment and engagement, clients can join one of the pre therapy groups, which help to: acclimatise them to group work; provide contact with others with similar difficulties; help them identify and clarify their problems; and get ready to move on to one of the intensive treatment tiers. The maximum time people can stay in these groups is 12 months. To reduce stigma and prevent barriers to accessing therapy, mental health notes for those without a previous trust record are anonymised until they enter intensive treatment or have contact with other trust services.

**Tier 2 - intensive outpatient therapy**

An 18 month treatment programme in this tier consists of:

- A weekly large group of up to 14 members, for 3-5 hours. Sessions draw on sociometric, dialectical behavioural, psychodramatic, cognitive behavioural, psychodynamic, cognitive analytic, transactional analytic and mentalisation based approaches;
- A weekly small analytic group (an open reflective space, facilitated in the classic group analysis style) of up to seven members;
- Occasional one to one meetings with staff based on a range of models to augment therapy, for data collection, and to facilitate engagement.

**Tier 3 - intensive treatment**

People attend a five day per week therapeutic community called Oxford TC (for more on therapeutic communities see Pearce and Haigh, 2008). This is also an 18 month programme and can be an alternative to tier 2, but people are free to move between the intensive therapy tiers as appropriate. The same range of therapy models is used in large groups, and work and activity groups. For both tiers 2 and 3 there is a 24 hour year round telephone support network operated by members (clients who have entered a group).

**Tier 4 - support after treatment**

When clients have been in therapy for 15 months in tier 2 or 3, they are expected to engage with tier 4. This consists of a rolling 16 week fortnightly programme on “life beyond therapy” to help them move on. Connections are made with external education and employment agencies and people also have the opportunity to become part of a social network. The service continues to hold clinical
responsibility for each person for six months after completing therapy and an exit interview is offered to all members and a summary is provided on the experience and process of therapy.

Support, training and recovery service

After successfully completing a treatment course, former service users can join the support, training and recovery service (STARS) network and get involved in providing clinical services.

There is also a friends and families programme, in partnership with Rethink. This consists of an eight week educational group, which leads onto a fortnightly support group, and is open to anyone with a loved one affected by personality disorder or similar problems. This work with carers is currently being included in a national strategy.

Evaluation

Anonymised data from the OCNS is externally evaluated by Imperial College and the Mental Health Foundation and there is also a continuous internal auditing process. A randomised controlled trial is currently in progress. Clinical questionnaires are used to measure individual members’ progress and the service as a whole.

A recent internal audit showed a 50% increase in referrals over a six month period. Evaluation is key in a climate of NHS resource constraints. This therapy programme is not a quick fix but a 2-3 year process. Brief therapy currently has a high profile, and although we acknowledge its value, there are limits to its long term effectiveness in personality disorder.

Audit and evaluation of our service has shown:

• High levels of client satisfaction, less dependence on benefits, high rate of return to education and employment;
• A 50% reduction in psychological medication;
• A 50% reduction in visits to A&E;
• A 70% reduction in admissions to psychiatric hospital;
• A 65% reduction in visits to psychiatrists/mental health teams.

Next steps

Tier 4 needs to be re-evaluated; endings in therapy are known to be an uncomfortable process. Although this is normal and much can be gained for clients completing a healthy ending process, tier 4 was the last part of the service to be developed and in hindsight, it would be useful to start with the end in mind. We are now looking to view this tier as a thread that should start at engagement level and be an active strong link throughout the programme. A pilot in partnership with Restore, a voluntary mental health organisation, is looking at this issue.

Background

• The American Psychiatric Association’s (2002) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) lists 10 personality disorders, with an additional category for behavioural patterns that do not match these but do exhibit characteristics of a personality disorder.
• According to the DSM-IV, a diagnosis must satisfy general criteria, such as experience and behaviour deviating markedly from the expectations of the person’s culture, as well as specific criteria listed under the specific personality disorder.
• There is a large variation in the reported prevalence of this condition, which can be explained by differences in sampling procedures, diagnostic instruments and the categories
included (Coid et al, 2006).

References:


Readers' comments (2)

- YVonne Williams | 19-Jan-2010 5:48 pm
  I am really interested in these kind of places working with Personality Disorder clients in the community. Sounds very interesting and seem to increase the role of the nurse from administering medication to being a therapist which is often overlooked.
  Unsuitable or offensive?

- Plinkering | 21-Jan-2010 5:41 pm
  Well now, this is a model that seems to approach the flexibility and needs that really are presented by patients in the community.

  I hear the Main House approach in Birmingham currently is undergoing changes and that Birmingham perhaps may have a service in the future that does better than treating up to 25 persons per year. Although its accurate to say for several years it has only been treating on average 12 people out of its 25 bed allocation ....

  This is a good article. Timely for some to read in Birmingham too ..