Brief report

The use of inpatient services in patients with borderline personality disorder

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Abstract

Objectives: To examine why five patients with borderline personality disorder were contributing to a high bed occupancy and high staff turnover on a general adult psychiatry inpatient unit.

Method: A retrospective audit looking at these individuals' service pattern use for the two-year period between 2001-2003 was undertaken. A new admission policy was then introduced. The policy was that admissions were agreed, where possible, at consultant level and, if deemed unavoidable, were time limited. The audit cycle was repeated for the next two year period, 2003-2005 and a third audit cycle was then performed for the period 2005-2007.

Results: Following the new admission policy, there was a 95% reduction in bed days for this group. Untoward incidents by these individuals reduced by 93% and attendance at Accident and Emergency was also significantly reduced.

Conclusions: By limiting the frequency and length of admissions there was, unsurprisingly, a reduction in adverse incidents which lead to significant problems for patients and staff alike.

Introduction

Patients with personality disorder place heavy burdens on general adult psychiatric services. A recent Scottish study found that 7% of admissions to general psychiatric inpatient units had a diagnosis of personality disorder.[1]

A study which compared borderline personality disordered patients with other personality disorder groups and major depression found that borderline patients had the highest utilisation rates of all services including inpatient services.[2]

Government policy has indicated that Health Service Trusts in England should develop dedicated personality disorder services.[3] In Northern Ireland consideration is now being given to the development of such services.

However, at the time this audit was performed, there were no dedicated personality disorder services and no plans for the development of such services or resources earmarked for this group of patients.

In late 2003, we were experiencing difficulties in our acute general psychiatric inpatient unit. In common with many other areas, we were experiencing considerable pressures on our beds, having to discharge the least severely ill patients to admit other patients. There was poor staff morale with increasing periods of sick leave, among nursing staff, in particular. It became apparent that five patients, diagnosed clinically by the consultant as suffering from borderline personality disorder[4] were having frequent crisis admissions. Some of these admissions ended up being quite lengthy, one being over three months in duration.

Patients with borderline personality disorder characteristically behave in an impulsive manner. Many such patients also behave manipulatively. The problems associated with these behaviours can be further compounded by staff counter transference, etc. The behaviour displayed by this group of patients had resulted in many violent, untoward incidents. the incidents occurring in clusters; 11 in the period November 2002 to January 2003 and 11 in the period October 2003 to November 2003. Incidents were particularly likely to occur if more than one of these patients were inpatients at the same time.

It was felt that there was a clear association between the admission patterns, the clusters of untoward incidents and the Human Resource issues. It was the view of staff, and particularly the consultant, that inpatient treatment was not beneficial, and probably harmful, to these patients. Consultation between medical and nursing staff resulted in a new management policy being developed for all patients with borderline personality disorder and, in particular, for these five identified patients. Admission to the inpatient unit was to be avoided if possible. It was acknowledged that there would be times when crisis admission might be appropriate/unavoidable, particularly out of hours. Where possible, such admissions were to be agreed at consultant level. Such crisis admissions were also to be limited to one or two days where possible.

Audit cycle

Prior to the introduction of the new admission policy, a retrospective audit covering the preceding two years between December 2001 and December 2003 was undertaken. The audit cycle was then repeated between December 2003 and December 2005, with a third cycle being completed between December 2005 and December 2007. We were interested in whether or not the intervention reduced the extent of services utilisation. We also wished to consider whether or not limiting access to the inpatient unit would result in more frequent presentations to the patients' general practitioners or the Accident and Emergency Department. We, therefore, retrospectively reviewed psychiatric records, incident report forms, Accident and Emergency records and general practitioner records.

We collated figures for the number of admissions for each

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patient during each two-year period, the number of inpatient days, number of untoward incidents (characterised as those resulting in deliberate self-harm, harm to others or absconding from the inpatient unit), outpatient contacts and attendances at Accident and Emergency and general practice.

Results

Use of inpatient facilities

In the two-year period prior to intervention these five patients were admitted on 30 occasions, resulting in 786 bed days. Between 2003 and 2005, there were 19 admissions and 101 occupied bed days. From 2005 to 2007 there were only 10 admissions totalling 35 occupied bed days. Following the intervention there was a 95% reduction in total occupied bed days (see Figure 1).

Contacts with outpatient services

In the first two years post intervention there was only a slight decrease in the frequency of outpatient contacts, these reducing from 221 to 197. In the third audit cycle attendances reduced further to 110 outpatient contacts, an overall reduction of 50% (see Figure 2).

Untoward incidents

Untoward incidents reduced significantly from 27 in the two years prior to intervention to four and two in the following two cycles respectively, a 93% reduction over the four year period (see Figure 3).

Other health care attendances

During the first two-year cycle our patients presented 44 times at Accident and Emergency with thoughts of self-harm or actual self-harm. In the following two cycles this was reduced to total attendances of 17 and nine respectively.

We were only able to obtain information relating to attendances in primary care for four of the five patients (one patient never responded to requests from her general practitioner for release of the information). We examined all presentations for both psychiatric and non psychiatric complaints. Prior to the intervention our patients presented to their general practitioners on 189 occasions, 56 of which were for psychiatric reasons. In the first two years after the intervention there were 355 presentations to the GP, 100 for psychiatric reasons. In the subsequent two years there were 257 attendances but only 35 of these were for psychiatric complaints. Overall, there was a reduction of 38% in the frequency of primary care psychiatric attendances during the course of the audit (see Figure 3).

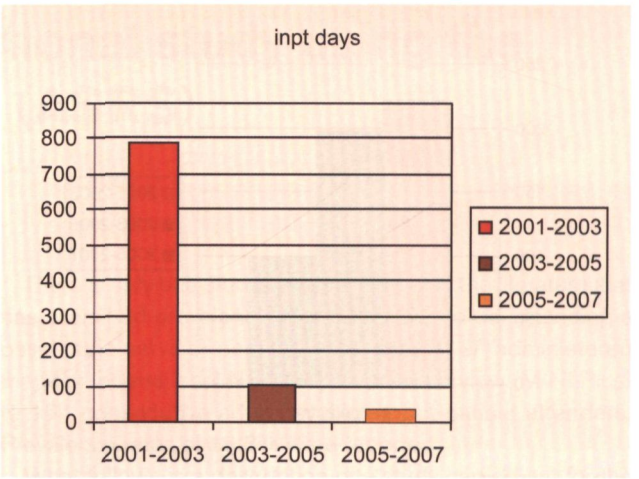
Current status

Of the five patients, four continue to attend psychiatric outpatients, only one of whom has had any inpatient treatment since the completion of the third audit cycle. The 5th patient attends infrequently with her GP and, overall, the pattern of service utilisation continues at a relatively low level.

Discussion

Due to difficulties in managing a small number of patients with borderline personality disorder, a new policy, with the aim of limiting the frequency and duration of admissions, was implemented. As a consequence of this change in practice,

Figure 1: Total occupied bed days



there was a 95% reduction in the use of inpatient facilities. Not surprisingly, there was a corresponding reduction in the number of untoward incidents with a consequent probable lessening of the associated negative impact on patients and staff. Attendances at the outpatient clinic and local Accident and Emergency Department decreased. After an initial increase, there was also a decrease in the number of primary care attendances for psychiatric problems. Most of the consultations leading to the initial increase in frequency of attendances were GP-initiated and related to one patient, the GP insisting the patient attend in person for prescription renewal because of his concern about further self-harm. Overall, the restriction on admission to psychiatric inpatient services did not seem to lead to a compensatory increase in the use of other services.

We were not in a position to measure sick leave among nursing staff but, anecdotally, there was an improvement in staff morale with staff being better able to cope with the patients' behaviour. Rather than defusing crisis and improving the overall wellbeing of these patients, inpatient treatment seemed to escalate the seriousness of self-harm with increased frequency of incidences of violence towards staff.

Comment has previously been made about the potential for iatrogenic harm from some traditional psychotherapies used to treat borderline personality disorder.[5] That particular paper provides little insight as to whether recurrent hospitalisations may cause iatrogenic harm, something previously suggested by other commentators using terms such as "hospital dependency" and inducement of "addiction to hospital".[6]

We believe this small audit does provide some support for these concepts.

With hospital admission being restricted, we would suggest that our patients were encouraged to accept a greater degree of personal responsibility for their condition, their actions and the consequences of these actions.

Encouragingly, their previous dependence on hospital services does not appear to have transferred to other services.

We encountered some difficulties with primary care colleagues and colleagues in the Accident and Emergency Department who previously had little resistance to these patients being admitted. We did not, as we should have, discuss in advance the change in management of these patients.

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Figure 2: Total outpatient contacts

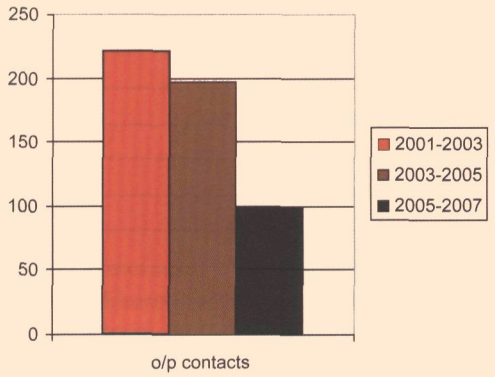
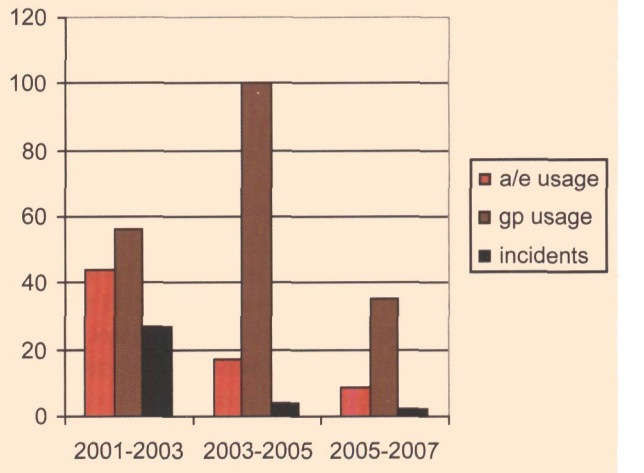


Figure 3: Untoward incidents and other health care attendances



Several informal communications were required to re-enforce the view that hospital admission was inappropriate and to support colleagues in alternative management.

For the consultant psychiatrist, it was difficult resisting admission, the previous standard way of dealing with the difficulties the patients presented.

Resisting admission, and proceeding with planned discharge, when patients were threatening or engaging in serious self-harm, when relatives were threatening legal action should a serious untoward incident occur and when non psychiatric colleagues were unsupportive, were often decisions followed through with difficulty. The consultant had to deal with his own uncertainty about whether or not this was the correct approach for these patients, aware that he would, at least, be subject to much criticism in the event of a patient causing serious harm to herself or others or taking her own life.

Limitations

We did not specifically interview the patients, their relatives, primary care or Accident and Emergency colleagues to ascertain their views about the change in service. The unwillingness of one patient to allow us to examine her general practitioner records may have been indicative of dissatisfaction.

However, a recent study of patients with borderline personality disorder found no correlation between those who were high users of facilities and satisfaction with services.[7]

Secondly, there were only a small number of patients included in this audit and the audit looked at the practice of one consultant team in one locality. It is common for individuals with borderline personality disorder to have fluctuations in the intensity of contact with services. Consequently, these findings could not necessarily be viewed as transferable to all patients with borderline personality disorder or to the practice of other clinical teams.

Thirdly, patients with borderline personality disorder mature, engage less in self harm and make less use of inpatient services as they get older. While there may be some contributions from maturation to the reduction in resource utilisation, we do not believe that this can explain such a dramatic reduction in use of resource, because this would suggest that, coincidentally, each of the patients matured significantly over the period the audit was undertaken.

Finally, the findings of this audit are essentially negative, ie. the findings indicate that inpatient treatment in a general psychiatric ward was not beneficial for these patients. On the basis of this audit, we clearly cannot comment upon what other services or treatments might be beneficial for these patients.

Conclusion

This audit has shown that, for a small group of patients with borderline personality disorder, a firm admission policy can markedly reduce the frequency and length of inpatient admissions. Hospitalisation of these patients is not necessarily beneficial, encouraging dependency and allowing patients to abdicate responsibility for their actions. Other, potentially more appropriate, treatments for this difficult group of patients need further evaluation.

Declaration of Interest: None

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