Government of **Western Australia**
Department of **Health**

Clinical Pathway for the Acute Inpatient Care of Emotionally Unstable Personality Disorder

Development, Implementation and Evaluation: Royal Perth Hospital's Experience

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Background

- Clinical practice guidelines for EUPD published by The National Institute for Clinical Excellence (2009) , and National Health and Medical Research Council (2012)
- Guidelines emphasised:
  - The importance of avoiding inpatient mental health admissions
  - When an admission is clinically indicated due to acute risk to self or others, length of admissions should be brief

Background

However:

- Patients with EUPD have been found to be one of the highest users of inpatient and emergency department services (Ansell, Sanislow, McGlashan, & Grilo, 2007; Bender et al., 2006; Hörz, Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010; Zanarini, Frankenburg, Hennen, & Silk, 2004).
- An estimated 72% of patients with EUPD will require hospitalisation in the course of their treatment (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004)
- Represent between 25% and 30% of all psychiatric admissions (Zimmerman, Chelminski, & Young, 2008).
- Length of hospitalisation rarely brief (Dasgupta & Barber, 2004; Nelson, 2013).
- Repeated presentations (Dasgupta & Barber, 2004; Nelson, 2013).

Rationale

- Inpatient services will have ongoing role in care of EUPD patients

- Furthermore, there has been no published research evaluating the feasibility or effectiveness of translating these guideline recommendations in the inpatient setting

Therefore, RPH embarked on an initiative to bridge the gap between evidence and practice by designing a Clinical Pathway for the acute inpatient care of patients with EUPD

Outline

- **Context**
- **Developing the Clinical Pathway**
- **Implementation & Education**
- **Clinical Pathway**
  - **Diagnosis**
  - **Safety Planning**
  - **Skills Group**
  - **Crisis Management Planning**
  - **Patient Controlled Crisis Admissions**
- **Evaluation**

Context – Royal Perth Hospital (RPH)

- Large tertiary hospital in Perth, Western Australia

- Mental Health Unit:
  - 20 bed, non-authorised psychiatric facility
  - Staffed by a multidisciplinary team
  - In Central Business District
  - Provides services across WA, regardless of residential area (i.e., no catchment)
  - Patient mix: mood disorders, personality disorders, acute reactions, schizophrenia, substance use disorders
  - Personality disorders – 30-40% of patient mix per year, and high usage of ED services

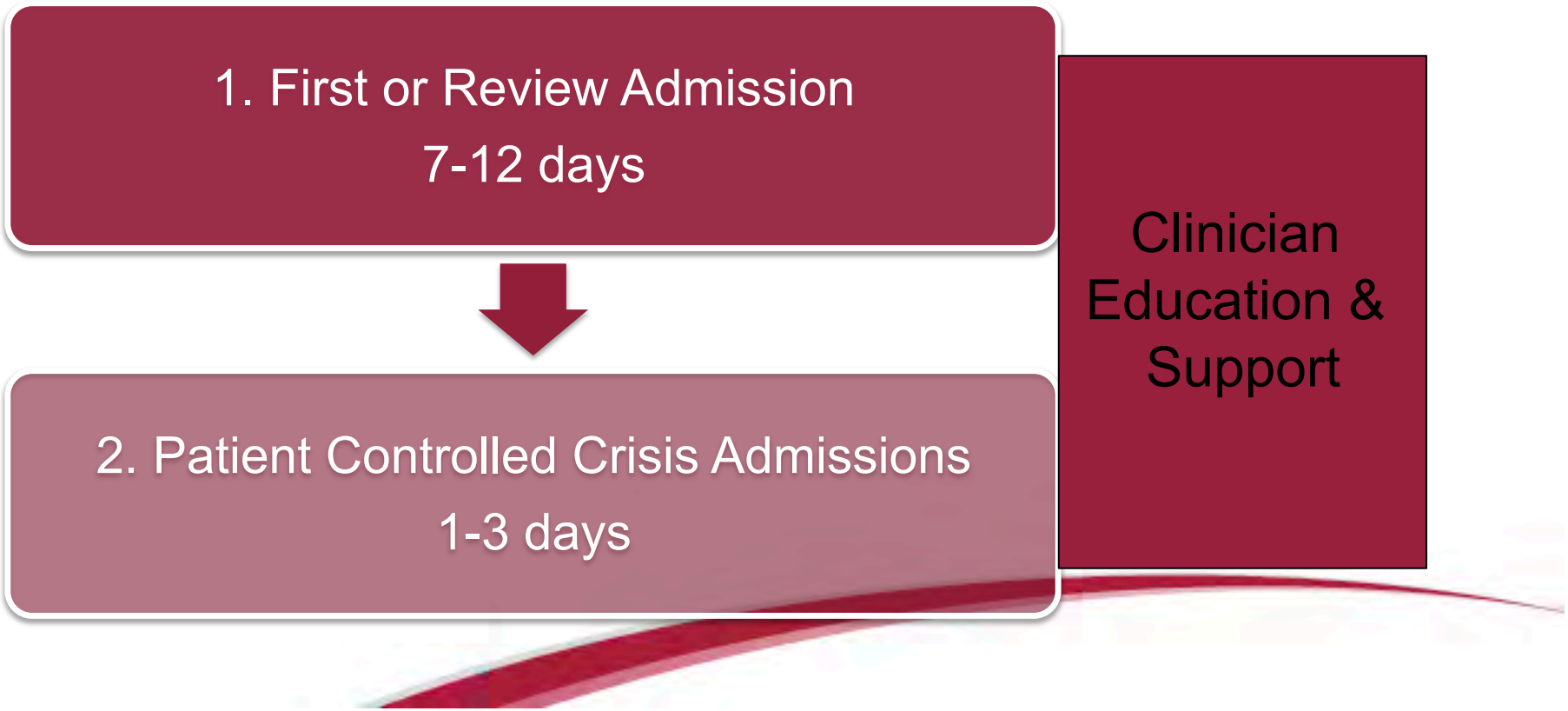
Development of the Clinical Pathway

- Developed in four stages between June 2011 – June 2013
- Developed in consultation with representatives from each discipline

  - Stage One: Gathered evidence
  - Stage Two: Review of existing services
  - Stage Three: Iterative drafting and review of Pathway
  - Stage Four: Implementation

Two Staged Clinical Pathway:

Two-staged approach designed to balance the recommendation of brief admissions with the need to validate patient's experience and deliver high quality care that covers all the recommendations:



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To provide an evidence-based structure and clear processes

For Clinicians
- To be confident, clear and consistent in their care

To enable patients, while on the ward
- To learn and practise healthy skills for coping with distress
- To link with community supports, and
- To build self-efficacy and 'a foundation' for living well in the community

Step 1: Admission

1. Provide prompt orientation to the ward to allow the patient to feel a sense of structure and safety, and to minimise the chance of further escalation of distress
2. Consider room allocation – avoid placing with others whose presentation may exacerbate distress or reinforce maladaptive behaviours

Step 2: Assessment

Nursing Assessment

3. Complete admission interview and checklist (physical, risk and drug and alcohol assessment, group contract & outcome measures)
4. Complete the Inpatient Safety Plan with the patient
5. Provide patient with a copy of the their Inpatient Safety Plan, group contract and Mental Health Act information
6. Provide patient with GP info sheet and confirm GP details. If GP is required, flag in management plan and provide patient with list of GPs in their area
7. Contact GP, community case manager & patient nominated significant other to inform them of admission
8. Complete PSOLIS data entry of K10 & HoNOS and check for existing Management or Crisis Management Plans

Medical Assessment

Within one working day Registrar, Intern & Key Worker Nurse (KWN) to complete Assessment Interview:

9. Ensure both KWN and the medical team are present in the first assessment
10. Complete the comprehensive psychiatric assessment as outlined in the standardised assessment document, including the standardised physical health assessment
11. Medical Team to contact patient nominated primary support person, case manager and any other service provider for collateral information and invite to attend a Care Planning meeting

Step 3: Diagnosis & Formulation

Registrar to integrate the assessment information (obtained via several sources) to finalise assessment proforma with:

12. Diagnosis based on an assessment of the person's enduring and pervasive patterns of emotional expression, interpersonal relationships, social functioning and views of self and others when they are not suffering from another mental disorder. If unsure, seek the opinion of a senior colleague
13. Confirm the diagnosis collaboratively with the patient
14. Document how the patient meets criteria (using ICD-10 criteria) and why an alternative diagnosis does not apply. This is to justify the diagnosis and to facilitate a shared understanding within the treating team of the traits of the individual patient
15. Formulation: Describe the current situation and the reasons for presentation. Include the hypothesised predisposing factors, precipitating factors, maintaining factors, protective factors and predicted barriers to treatment

Step 4: Comprehensive Multidisciplinary Management Plan

A comprehensive management plan is generated in PSOLIS and each member of the multidisciplinary team is to contribute:

16. KWN to generate comprehensive management plan in PSOLIS and complete relevant sections
17. Registrar and Allied Health to complete comprehensive management plan in PSOLIS adding relevant components as outlined below

Purpose of Admission

18. Registrar to document clearly in PSOLIS the purpose of the inpatient admission (Consider diagnostic clarification and linkage with community supports)

Nursing Management

19. KWN to document planned nursing management (within 24 hours of admission) of all core symptomatology and comorbidities identified in the assessment

Safety Promotion

20. KWN and Registrar to document clearly the risks (e.g., of self-harm, violence, absconding, violence and drug and alcohol use) identified in their assessments
21. KWN to document the patient's plan for mitigating risks as outlined in their Inpatient Safety Plan
22. Registrar to document the plan for managing the risks should they eventuate, ensuring specificity of behavioural boundaries and non-punitive, trauma-informed consequences for breaches

Pharmacotherapy

23. Registrar to review all psychotropic medication; where inappropriate, reduce or cease in consultation with patient and the original prescriber
24. Registrar to remind the patient about the limited evidence-base for the use of pharmacotherapy for personality disorders and the corresponding stronger evidence-base suggesting psychotherapy is more effective
25. In acute agitation or distress, use pharmacological agents only when 1st line (non-pharmacological) treatment options have been unsuccessful. Select a drug that has a low side effect profile, low addictive properties, minimum potential for misuse and relative safety in overdose, such as a sedative antihistamine
26. In prescribing a pharmacological agent for co-occurring conditions, establish likely risks of prescribing, including alcohol and illicit drug use, and risk in overdose
27. Registrar to document the agent, dose, target symptoms and review intervals in the management plan and communicate this to other prescribers involved in the patient's care

Physical Health

28. Registrar and KWN to document the planned medical management, including referrals to other medical specialties, as indicated by the physical examination and medical history. Consider dental, sexual health, pain management, cardiology & endocrinology

Alcohol and Substance Use

29. KWN to document alcohol and substance use management as per ASSIST

Group Therapy

30. KWN and/or Registrar to identify group sessions appropriate for the patient, KWN to ask patient to sign group contract. All staff to encourage attendance as an integral part of treatment

Allied Health

31. Registrar to consider referring to Clinical Psychology for comprehensive psychological assessment and short term psychological intervention
32. Clinical Psychology to document in PSOLIS their planned management
33. Registrar to consider referring to Occupational Therapy to address personal, domestic and occupational functioning
34. Occupational Therapist to document in PSOLIS their planned management
35. Registrar to consider referring to Social Work to address all areas of social functioning
36. Social Work to document in PSOLIS their planned management

Length of Stay

37. Registrar to estimate the **date of discharge**. First Admissions requiring comprehensive assessment and community linkage (usually 7-10 days).

Linkage to Community Services

38. Registrar to collaborate with existing community services and complete referral to new outpatient services to support patient's longer-term recovery
39. Medical team to book Care Planning meeting with the patient's nominated primary support person, carer and/or outpatient service providers

Crisis Management

40. For patients with a history of poor help-seeking behaviours, frequent use of emergency department and inpatient services and life threatening behaviours (i.e., non-suicidal self injury and/or suicide attempts), consider a formal plan for the management of future crises, including patient-controlled crisis admissions, outlined in a Crisis Management Plan on PSOLIS.

Step 5: Communicating The Diagnosis & Management Plan

41. Medical Team to communicate the diagnosis and formulation to the patient in a sensitive and accessible manner. Explore treatment options and convey optimism about their recovery
42. Provide patient with a copy of the EUPD fact sheet and invite them to ask any questions
43. Provide verbal and written information on each aspect of the patient's planned management, as per the management plan to the patient. Include the group programs offered, medications prescribed (including benefits and possible side-effects), the behavioural boundaries and pre-determined and agreed consequences for breaches (e.g., alcohol use or self harm) and the plan for discharge (i.e., estimated date of discharge, outpatient services offered and the plan for plan for management of future crises).
44. Share actions 41-43 with the patient's nominated primary support person at the Care-Planning meeting

Step 6: Review & Revise

45. All available MDT members to attend Daily MDT Meeting. Registrar to run review of management plan, risk assessment, allied health referrals & discharge planning
46. Nursing staff to conduct three times daily shift handovers
47. All MDT members to attend Weekly Multidisciplinary Team (MDT) review. PSOLIS Management plan reviewed, updated, printed, signed by patient and filed

Step 7: Discharge

48. Medical Team to meet with the patient before discharge to review mental state. If patient is fit for discharge, notify KWN, order medications and complete the Discharge Summary
49. Medical Team to review and explain the patient's plan for managing future crises (Discharge Safety Plan or Crisis Management Plan) and discuss any concerns the patient may have about discharge
50. KWN to assist patient to finalise Discharge Safety Plan, notify significant other/s of discharge and complete all discharge documentation including a Crisis Management Plan in PSOLIS if aplicable
51. Medical Team to ensure a copy of the Discharge Summary, Care Transfer Form, Discharge Safety Plan or Crisis Management Plan is provided to their primary care provider (GP) and their primary support person (where consent obtained)
52. Medical Team to ensure effective collaboration with other care providers, and notify them of the patient's discharge to ensure prompt pick up

Step 8: Transfer of Care

53. Discharge Support Program (DSP) to initiate follow-up phone call within one week of discharge to assess individual's adjustment to community living, and current mental state
54. DSP to offer transitional support in the form of crisis support from the DSP CNS during office hours and group and/or individual psychological therapy for up to six weeks post discharge
55. DSP and patient to work collaboratively to promote engagement with community services

Step 9: Crisis Admission

When patients' internal strategies and external supports are insufficient in managing acute distress and risk of harm, a patient-controlled brief hospitalisation or 'Crisis Admission' may be necessary:

56. Allocate patient to the treating team responsible for their care during their previous MHU admission
57. Registrar and KWN to conduct a comprehensive mental health assessment which focuses on the precipitants of the crisis, avoids unnecessary history taking and validates the patient's experience and use of the Crisis Management Plan as an adaptive coping strategy
58. Registrar and KWN to discuss with the patient, the goals and planned length of stay for the Crisis Admission (i.e., 1-3 days) and complete the Crisis Admission Management Plan
59. KWN and patient to review and update the Inpatient Safety Plan and Crisis Management Plan
60. MDT to ensure that the patient is reconnected with community support services prior to discharge

1. Refers to Action Points which are only applicable to patients with a diagnosis of EUPD. All other Action Points should be completed for all patients.

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Pathway: Stage One – *Collaboratively Determined Diagnosis*

- Communication of diagnosis to patient essential
  - To offer patient explanation for their experience, empower them to engage with own treatment and promote optimism and hope in recovery based on a link to proven treatments

- Medical Team & Clinical Psychology Training
  - Education workshops, role play of providing diagnosis in therapeutic manner, in context of formulation
  - 2 page example script in Clinician Handbook

Pathway: Stage One – *Safety Planning*

- Proactive strategy to ensure safety on ward
- Collaboratively developed with patient
- Step-by-step plan using prompting questions, patient's answers recorded in their own words
- Identifies:
  - Triggers
  - Warning signs
  - Current coping strategies
  - Helpful coping strategies
  - A plan for when things escalate
- Patient and staff sign the plan to acknowledge understanding and commitment to using the plan during their inpatient stay

Pathway: Stage One – *DBT Skills Group*

- Three groups per week, 1.5hrs per Group
  - Mindfulness
  - Distress Tolerance/Affect Regulation
  - Effective Communication
- All diagnoses
- Nurse Therapist & Clinical Psychology facilitated
- Mixed Inpatients and Outpatients
- Outpatient can attend up to ~6 weeks post discharge as transition support
- Open / rolling flexible content

Pathway: Stage One – *Future hospital access*

Limitations with the traditional gatekeeper model:

- Establishes a power relation between the clinician and patient (Hoch, O'Reilly, & Carscadden, 2006; Krawitz & Watson, 2000).
- Patient feels compelled to accentuate visible distress to ensure the clinician gains an understanding and grants request for admission (McMahon & Lawn, 2011; Nehls, 2000; Strand & von Hausswolff-Juhlin, 2015).
- When admission is 'granted' in this way, it likely reinforces this accentuating behaviour and undermines the process of collaboration and personal accountability (Eastwick, 2005; Nehls, 1994, 2000).
- Increases the time needed to stabilise symptoms and recover from a crisis, extending the length of time in hospital.
- When denied admission, the patient's core beliefs activated and their communication of significant distress invalidated.
- This potentially perpetuates the invalidating environments in which their disorder was likely borne (Linehan, 1987; Linehan, 1993; Nehls, 1994, 2000).

Pathway: Stage One – *Future hospital access*

- Consequently, patients may exhibit intense emotional responses (serious self-harm, aggression or hostility)
- Has the potential to perpetuate unhelpful relationships with clinicians and the service and contribute to repeated presentations until an admission is granted (McMahon & Lawn, 2011).
- This highlighted the need to consider alternatives to the traditional gatekeeper model.

Pathway: Stage One – *Patient Controlled Admission Plan*

Patient works with team to develop an extension of their safety plan, that documents steps they are to take to reduce distress and risk of suicide or self harm following discharge, including the option of presenting to ED when other resources are insufficient in reducing risk; guaranteed a bed pending availability for:

Patient Controlled 3 Day Crisis Admission.

- Transfers responsibility of assessing emotional state from health care services to the individual themselves – fostering self-responsibility
- Ensures patients do not have to escalate, self harm or attempt suicide to ensure admission, shifts the power differential and breaks cycle of maladaptive help seeking
- Ensures patients are less resistant to discharge through ease of admission

Pathway: Stage Two – *Crisis Admissions*

- By eliminating the need to engage in unhelpful behaviours to gain admission and having the understanding of hospital staff, more quickly ‘contain’ the patient and allow him/her to focus on the strategies identified that will help de-escalate the distress
    - 1 x session with clinical psychologist to conduct ‘chain analysis’ of crisis
    - 1:1 with nurses
    - Attend group therapy
    - 6 more weeks of outpatient groups if deemed necessary
    - Re connect with community providers

Evaluation - Methods

- Design:
  - Single-centre combined clinical audit and historical control group design
- Historical control cohort:
  - Collected during Stage One of Development
  - 130 patients
- Clinical Pathway cohort:
  - 179 patients

Evaluation - Methods

- Outcomes:
  - Length of stay
  - Hours of Psychological Therapy attended
  - Psychiatric symptomatology (admission to discharge)
  - Patient satisfaction
  - Likelihood and number of readmissions
  - Likelihood and number of presentations to ED
  - Total Bed days

Participants

	Historical cohort	Clinical Pathway cohort
Number	130	179
Age (years)	35.5 ±12.2	33.7 ±11.1
Gender (% female)	59.1%	67%
Living Location (% Rural and Remote)	5.80%	5.00%
Ethnicity (% Aboriginal)	13.90%	14.50%
Self-Harm at Presentation of Index Admission (%)	16%	22%

Statistical Analysis

- Treatment effects regression
- Multilevel mixed-effects linear regression
  - To determine the group differences in changes in psychiatric symptomatology from admission to discharge
- All analyses conducted using STATA 14

Outcome Variable	Average Treatment Effect	95% Confidence Interval	
Attended Psychological Therapy	14.83%*	3.39%	24.40%
Psychological Therapy Hours attended	2.78*	1.02	4.59
Length of Index Admission (days)	−5.16**	−1.91	−8.05
Readmission	−6.03%	−18.62%	2.52%
Number of Readmissions	−0.75*	−0.19	−3.81
Re-Presentation to ED	2.91%	−4.75%	16.45%
Number of Re-Presentations to ED	−0.10	−0.48	0.28
Total Bed Days of Readmissions	−8.22*	−2.10	−17.51

*$p \leq 0.05$; **$p \leq 0.001$.
Each outcome and treatment model contains the following covariates; Age, Gender, Ethnicity, Living Location, EUPD Primary Diagnosis, Reaction to severe stress, and adjustment disorders, Depressive Disorders, Mental and behavioural disorders due to psychoactive substance use, Physical Health Disorders, Other Personality Disorder, Neurotic (Anxiety) Disorders, Bipolar Affective Disorders, Schizophrenia, schizotypal and delusional disorders

Sub-analysis: Patient Symptoms

- Patient symptomology was assessed on admission and prior to discharge using the BASIS-24.

- BASIS-24 Total scores:
  - Both Historical and Pathway cohort had statistically significant reductions over time
  - Symptomatology of Pathway cohort were not significantly different to Historical cohort on discharge

Sub-analysis: Patient Satisfaction

- Overall satisfaction was not significantly different between the two cohorts.

- Patients in Pathway cohort reported being more satisfied with their involvement in their treatment planning than patients in Historical cohort ($p < .005$)

Cost Effectiveness

	Average Treatment Effect[1]	95% Bias Corrected Confidence Intervals	
Length of Index Admission (Days)	**5.16**	1.91	8.05
Mental Health Bed days from Readmissions (Days)	**8.22**	2.1	17.51
Total Per Patient Bed Days Savings (Days)	**13.38**	4.01	25.56
Total Sample Bed Day Savings (Days)	**2395.02**	717.79	4575.24
Total Sample Savings (Savings)	**$3,592,530.00**	$1,076,685.00	$6,862,860.00
Program Investment	**$150,000**		
Total Return on Investment	**$3,442,530.00**	$926,685.00	$6,712,860.00

1. Calculated based on n=179 in treatment sample and the average cost of a bed day on the RPH MHU = $1500

Discussion

The implementation of the Pathway:

- Improved outcomes for individuals with EUPD in a number of areas
  - Hours of psychological therapy
  - Length of index and readmissions
  - Symptomatology
  - Satisfaction

Implications

- Clinical implications
  - Pathway provided a consistent model, in line with evidence-base for the provision of care for individuals with EUPD during their inpatient stay
  - Increased consumers' ability to manage within the community for longer periods of time

- Service provision:
  - Pathway allowed the MHU to take on a greater caseload within the 12 month period, therefore allowing more individuals access mental health care

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1. Refers to Action Points which are only applicable to patients with a diagnosis of EUPD. All other Action Points should be completed for all patients.

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Emotionally Unstable Personality Disorder

- EUPD ICD-10 equivalent to Borderline Personality Disorder (BPD)
- Affects over 500,000 Australians, with a lifetime prevalence of 2.28% (Jackson & Burgess, 2000).
- Common experiences include:
  - Extreme and poorly controlled emotional states
  - Impulsivity
  - Tumultuous relationships
  - Self destructive behaviours (American Psychiatric Association, 2000).
- Significant functional impairments and distress due these symptoms, which are often present across their social, family and work lives (Leichsenring, Leibing, Kruse, New, & Leweke, 2011b; Skodol et al., 2005).
- As a result, individuals with EUPD often present to hospital emergency departments seeking support through an acute inpatient mental health admission