original papers

TENNYSON LEE, DUNCAN MCLEAN, PAUL MORAN, HUGH JONES AND ANIL KUMAR

A pilot personality disorder outreach service: development, findings and lessons learnt

AIMS AND METHOD

We describe the development of a pilot personality disorder outreach service. A case series of 13 patients was studied. Data were collected using pro forma, semi-structured interviews and a structured assessment of personality disorder.

RESULTS

All personality disorder clusters were represented among the 13 patients.

Treatment recommendations usually supported the existing approach — the 'added value' of the outreach service was that difficult inter-personal dynamics could be considered and thought through with an objective observer. Opinions differed on whether the service was more useful for the assessment and brief treatment or continuing care teams.

CLINICAL IMPLICATIONS

Personality disorder services need to develop expertise in all clusters. There is a need to moderate the harsh self-critical attitudes of the care coordinators. The national framework for personality disorder is useful for service development, but the services need to be tailored to the individual needs of specific teams.

There is a clear need for the development of personality disorder services (National Institute for Mental Health in England, 2003). Unfortunately, many clinicians are reluctant to work with people with personality disorder because they believe they lack the skills, training and resources to provide an adequate service. We developed a pilot personality disorder outreach service at the Cawley Centre (a specialist unit for patients with inter-personal and long-term neurotic difficulties) in Maudsley Hospital, London. The service was aimed to provide consultation and support to care coordinators of patients with a primary diagnosis of borderline personality disorder in two general adult mental health teams. In this paper we describe the development, findings and recommendations of the service in the context of national guidelines (National Institute for Mental Health in England, 2003).

Method

We conducted a case series study of 13 patients. Data from all consecutive outreach visits carried out between 1 September 2005 and 30 June 2006 was collected. No similar study was identified in which the main target of the outreach service had been the care coordinator rather than the patient. We therefore developed our own pro forma as the most structured means of data gathering for the outreach visits. We conducted semi-structured interviews with consultant psychiatrists

before starting the pilot service and with the community mental health teams at the end; a modified thematic analysis was used to assess qualitative data thus obtained (Strauss, 1987). Personality disorder was diagnosed by interviewing care coordinators using the Standardised Assessment of Personality (Mann *et al*, 1997), a method previously used by Keown *et al* (2002) to assess prevalence of personality disorder among the patients seen by a community mental health team in London.

The consultant psychiatrists in all eight community mental health teams were all interviewed on an individual basis. We chose to work with two teams on the basis of what seemed the closest match between what the consultant psychiatrists requested and what our pilot service was able to offer.

We adopted a mentalisation-based treatment approach (Batemen & Fonagy, 2004) as it has the largest evidence base in psychodynamic treatment of borderline personality disorder. Key questions asked were: 'What is in the mind of the key worker?' and 'What does the key worker think is in the mind of the patient?' Treatment planning was developed taking into consideration the suggestions put forward by consultant psychiatrists, the resources available, key documents (Royal College of Psychiatrists, 1999; National Institute for Mental Health in England, 2003), recommendations from evidence-based models (Bateman & Fonagy, 1999; Bateman & Tyrer, 2003) and Trust guidelines (South London & Maudsley NHS Trust, 2001).

Results

There were 13 patients consulted, 11 women and 2 men; median age was 46 years old (Table 1). Two of them did not meet the DSM–IV criteria for a personality disorder (Mann *et al*, 1997). While the service had been developed with mainly borderline personality disorder in mind, all clusters were represented (three patients with Cluster A, six with Cluster B and seven with Cluster C personality disorder). Most consultations were performed on a one-off basis and therefore the user formulation and recommendations were preliminary. They were informed by the care coordinator's reports of interactions with, and feelings aroused by, the participant, rather than their detailed early history.

Case study

A single professional woman in her early 30s made frequent contact with a community mental health team in a very demanding and chaotic way, expressing thoughts of self-harm. She was assessed by a consultant psychiatrist who thought her risk of self-harm was low but her use of the service confused the team. She would contact the team, threatening to harm herself, but during the follow-up she was dismissive, leaving the team members feeling useless. She generated such strong and mixed feelings in the team that she was referred to our pilot service and merited a joint meeting with a personality disorder specialist and a key worker. As no clear picture emerged from this meeting, she was offered a course of four sessions with the personality disorder specialist with the aim of developing a formulation; she attended three sessions. A similar pattern emerged in how she related to the specialist, the team and her intimate partners – wanting attachment but becoming dismissive and contemptuous once she received it. During one of the sessions with the specialist there was a rather tantalising moment of some understanding developing, followed by withdrawal.

A meeting was arranged with the whole team. The defence mechanism she was thought to be using (compellingly described by Kernberg, 1967) was discussed – splitting and projective identification. Specifically, she split off her feeling of being contemptible and projected it to those around her. However, the countertransference problems did not only lie in feelings induced by contact with this woman but also in what the members of the team brought into the encounter, namely their desire that the woman improve. The final recommendations for the team were to continue in their pragmatic approach of responding when a person sought help but avoid being too interventionist and to accept the limitations to their service caused by resource constraints (in terms of time and staffing capacity). The team felt supported in their work and in the approach they had taken.

As this case study has shown, recommendations made by the outreach service were frequently supportive of the existent approach and the 'added value' of the service was a discussion of the dynamics which made the work of the community mental health teams difficult. In this case the discussion led to an acknowledgement of the existence of countertransference hate (Winnicott, 1947) in response to the patient's contemptuous use of the service and her use of projective identification. This may have helped in preventing the team developing a defence against it (Maltsberger & Buie, 1996).

Feedback from staff

Two key themes emerged from the baseline interviews with consultant psychiatrists. The first concerned the specialist *v.* general services – it was felt that the programme being offered may be too hands-off and consultative and that if a patient was seen jointly by a key worker and a personality disorder specialist, the former's expertise would not be appreciated. Also, there was an issue of the specialist service being prescriptive, divisive or adding more work, with the possibility of team members being too embarrassed or reticent to discuss their work with peers.

Another problem identified evolved around the scope of service. Of the consultant psychiatrists initially interviewed, some felt that the outreach service should take over clinical responsibility for all patients while others saw the outreach service as needless (in these teams the consultants and senior psychologist took most responsibility for patients with borderline personality disorder). Some believed that the service might be useful in supporting the care coordinator but not necessarily working directly with patients.

The two teams differed in whether they found the outreach service more useful for their continuing care or assessment and brief treatment functional teams, the former prioritising consultations on their long-term users, the latter – assistance with new users. The team which had initially wanted support for their assessment and brief treatment team only, at the end of the pilot also requested support for their continuing care team. The teams also considered it reassuring to know that they were taking the 'right' approach and thought there was a need for a bridging service to manage the discharge from a day service. Furthermore, they felt it would be useful for certain users to be assessed directly by the personality disorder specialist and fortnightly visits were carried out by our outreach service. Both teams wanted the service to continue.

Discussion

The pilot followed the following principles (National Institute for Mental Health in England, 2003):

- hub and spoke approach (the personality disorder service has a base which offers its core treatment programme and an outreach programme, providing consultation, liaison and support to general psychiatric services) – while this seems an efficient use of limited specialist services, it raises the ongoing tension between general and specialist services,

original
papers

Table 1. Demographic profile, diagnoses and recommendations of service				
Gender, age	Case note diagnosis	Personality disorder diagnosis[1]	Question from care coordinator	Recommendation
F, 34	Schizophrenia, borderline personality disorder	Paranoid, schizotypal, anxious/avoidant	What is the most appropriate care regarding duration, frequency of appointments?	• Reduce dependence on service • Ongoing review of diagnosis
F, 52	Bipolar affective disorder, personality disorder	Dependent, anxious/avoidant	How to deal with blaming attitude?	• Patient in state of melancholia and as such will continue judging self and others harshly • Bereavement counselling
F, 34	Schizotypal personality disorder	No personality disorder	What is the most appropriate approach?	• Continue (and be content) with present approach i.e. the objective of treatment is containment, not psychic change
F, 29	Borderline personality disorder	Borderline	Does she belong in mainstream psychiatry?	• To address her endless sense of entitlement and grievance: give patient experience of being heard but then negotiate limits to her expectations
F, 64	Depression	Dependent, anxious/avoidant	How to manage self-harm intent?	• Self-harm serves a function of keeping the husband engaged • Adopt systemic approach – review husband's role as carer
F, 34	Depression, borderline personality disorder	Borderline, anxious/avoidant	How to manage chaotic presentation?	• Continue present approach i.e. joint team approach • Be sympathetic and pragmatic, responding as needed while encouraging patient to take some responsibility back
M, 32	Schizophrenia, depression, alcohol dependent	Dissocial personality disorder	Given how much I have invested, what can I expect?	• Be satisfied with achieving containment rather than striving for psychic change • Test attachment by addressing alcohol dependence
F, 46	Personality disorder	Paranoid personality disorder	How to get the patient to psychotherapy? How to resolve relationship with son?	• Need to acknowledge patient's anxiety raising a son • Need to negotiate focus of work with patient e.g. children leaving home • Patient not presently at stage when they want individual psychotherapy
F, 47	Bipolar affective disorder, personality disorder	Dependent personality disorder	How do I respond to the patient's sense of futility and lack of responsibility?	• View role as supportive rather than achieving psychic change • Need to address psychiatric issues: consider increasing antipsychotics, monitor risk
M, 52	Personality disorder	Narcissistic, anxious/avoidant	The patient is overwhelming – where do I go to from here?	• Acknowledge containing role achieved by community teams • Continue encouraging patient to be more self-sufficient
F, 59	Depression, borderline personality disorder	Borderline narcissistic	She overwhelms me – what do I do?	• Need to negotiate focus of work • Meet with family
F, 44	Alcohol abuse, organic personality disorder	No personality disorder (has accentuated traits for anxious/avoidant)	Can I reduce intensity of work with her? Can I refer her to personality disorder day care service?	• Need to review patient again, insufficient time to formulate • Attempt to reduce intensity but anticipate patient responding with hostility
F, 49	Depression, personality disorder	Anxious/avoidant	I feel stuck – the patient is draining me	• Present level of care does not serve a useful function. Titrate care down • Refer to dietician

F, female; M, male.

1. Diagnosis based on ICD–10.

original papers

discussed above (the request by one team consultant for the outreach service to take on clinical responsibility for all referred people with personality disorder as opposed to our view, driven by limited resources, that the service's main task should be to support the work of the care coordinator, e.g. through one weekly session with a specialist registrar plus weekly supervision by the consultant psychotherapist)

- greater flexibility and assertiveness than conventional psychotherapy, as shown in the case study of a user whom the community mental health team struggled to engage with.

These findings can only be considered to be preliminary as the number of users and clinicians studied was small. In addition, negative feedback may have been limited as it was given to a personality disorder specialist who had visited and had been familiar with the teams. Nevertheless, on the basis of these data, we are able to make some tentative recommendations for clinicians thinking of developing a personality disorder outreach service:

- service providers need to develop expertise in the recognition and management of people with a variety of personality disorder subtypes
- there is a need to moderate the harsh self-critical attitudes of care coordinators who might berate themselves when users fail to make the type of treatment progress possible only with far more intensive, long-term work
- each outreach service needs to be developed within the broad parameters of the national framework (National Institute of Mental Health in England, 2003) – here the service needed to fit in with the working patterns of the teams
- offering a specialist service may arouse tensions in general teams; these have to be carefully managed.

Declaration of interest

None

Acknowledgements

References

BATEMAN, A. & FONAGY, P. (1999) Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American Journal of Psychiatry*, **156**, 1563–1569.

BATEMAN, A. & TYRER, P. (2004) Services for personality disorder: organisation for inclusion. *Advances in Psychiatric Treatment*, **10**, 425–433.

BATEMAN, A. & FONAGY, P. (2004) *Psychotherapy for Borderline Personality Disorder – Mentalization Based Treatment.* Oxford University Press.

KEOWN, P., HOLLOWAY, F. & KUIPERS, E. (2002) The prevalence of personality disorders, psychotic disorders and affective disorders amongst the patients seen by a community mental health team in London. *Social Psychiatry and Psychiatric Epidemiology*, **37**, 225–229.

KERNBERG, O. F. (1967) Borderline personality organization. *Journal of the American Psychoanalytic Association*, **15**, 641–685.

MALTSBERGER, J. T. & BUIE, D. H. (1996) Countertransference hate in the treatment of suicidal patients. In *Essential Papers on Suicide* (eds J. T. Maltsberger & M. Goldblatt), pp. 269–289. New York University Press.

MANN, A. H., RAVEN, P., PILGRIM, J., *et al* (1997) Standardised Assessment of Personality ICD–10 & DSM–IV version. Institute of Psychiatry.

NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (2003) Personality disorder: no longer a diagnosis of exclusion. Department of Health.

ROYAL COLLEGE OF PSYCHIATRISTS (1999) Development of Psychological Therapy Services: Role of the Consultant Psychotherapist. Royal College of Psychiatrists.

STRAUSS, A. (1987) *Qualitative Analysis for Social Scientists.* Cambridge University Press.

SOUTH LONDON & MAUDSLEY NHS TRUST (2001) Report of the Working Party on the Management of Deliberate Self Harm, Borderline Personality Disorder (BPD) and Related Problems. SLAM NHS Trust.

WINNICOTT, D. W. (1947) Hate in the countertransference. In *Through Pediatrics to Psycho-Analysis* (ed. D. W. Winnicott), pp. 194–203. Hogarth Press, 1958.

*Tennyson Lee Consultant Psychiatrist and Psychotherapist, Tower Hamlets Personality Disorder Service, East London NHS Foundation Trust, Mile End Hospital, London E1 4DG, email: tennyson.lee@eastlondon.nhs.uk, **Duncan McLean** Consultant Psychotherapist, Cawley Centre, Maudsley Hospital, London, **Paul Moran** Clinical Senior Lecturer, Institute of Psychiatry, London, **Hugh Jones** Consultant Psychiatrist, South London & Maudsley NHS Foundation Trust, **Anil Kumar** Consultant Psychiatrist, South London & Maudsley NHS Foundation Trust