Dr. Josh Berezin (00:07):

Welcome to our podcast, Psychiatric Services From Pages to Practice where we highlight new research or columns published this month in the Journal of Psychiatric Services. I'm the journal's podcast editor, Josh Berezin. Lisa's out today, but we have two guests from the UK to talk with us about a service system for people diagnosed with borderline personality disorder. Just a note, you'll hear references to A&E a number of times before I actually ask our guests to define it, but that's accident and emergency for our non-UK listeners and it's equivalent to emergency room in the US. So we're very excited to have Dr. Simon Graham and Kathy Curtis, who is a registered mental health nurse at the Spring House Psychotherapy and Personality Disorder Service, here to talk with us about their paper, Designing Community Services for People with Borderline Personality Disorder to Reduce Hospitalization. So Simon and Kathy, thank you so much for joining us.

Ms. Kathy Curtis (00:07):

Thank you for having us.

Dr. Simon Graham (01:00):

Thank you very much, Josh. We're looking forward to having a discussion with you over the next half hour.

Dr. Josh Berezin (01:04):

So maybe just to start, tell me a little bit about both of your backgrounds and how you came to collaborate on this particular project.

Dr. Simon Graham (01:12):

Should I go first?

Ms. Kathy Curtis (01:13):

You go first. Yeah.

Dr. Simon Graham (01:15):

So I think when I was a junior doctor, I thought I wanted to work in the emergency department, and then I got a sense that it was quite a hectic, busy life and I found my way drifting to psychiatry. And once I started training in psychiatry, I really found a passion for working in psychotherapy and trained up in a number of models through my training. What then happened was working on the wards, I came across my first ever patient with personality disorder. What had been occurring was that I'd been on an inpatient job and the patient had been receiving ECT for four or five months and not getting better. And the plural consultant in charge of the treatment was getting perplexed.

(01:57):

And I remember the senior junior doctor next me nudged me and said, "He's got the wrong diagnosis," and said, it's borderline personality disorder. I'd never heard of that before. So I became really interested in this new diagnosis, but also the impact it was having on the system, a person in hospital for almost a year. The doctor was trying all sorts of heroic treatments. And so I started my journey into understanding what borderline personality disorder was at that point. As I got further along in my training, I specialized in getting training in personal disorder, and then when I became a consultant, the opportunity to create the service here evolved.

Ms. Kathy Curtis (02:38):

So I worked for 20 years in a high secure mental hospital on personality disorder at Ward's, and we did see it was a male hospital, so we did see some borderline personality disorder patients in there, but I think that's obviously historically and currently is still a diagnosis more afforded to females. But the treatment was in that setting, it was counter-therapeutic really, and therapy was really severely inhibited by the secure environment and the restrictions around patients. So after 20 years, I saw an opportunity for a change, which was when a position came up here in Spring House, which was working with personality disorder, specifically borderline personality disorder. So it still fulfilled my interest in personality disorder rather than mental illness, but from an absolutely opposite perspective and approach.

Dr. Josh Berezin (03:43):

Opposite though, it sounds like both of you were motivated by seeing things go poorly that we're looking at something you're like, this could be a lot better and we could be providing a lot better treatment and services for this population.

Ms. Kathy Curtis (03:58):

Yeah.

Dr. Josh Berezin (03:58):

As you're talking, I realize even the word consultant, it might be helpful just to take a step back and tell me in our audience a little bit about any background that you think we might need to know about mental health services in the UK in order to understand what you all put in place.

Dr. Simon Graham (04:15):

Yeah, no, that's a good thing, Josh. And the most important thing about healthcare in the UK is predominantly within the National Health Service. So when we pay our taxes, that then funds the National Health Service and it's free at the point of access. So we don't have very many health insurance companies with very big share of the markets. And within that, within the NHS, you've usually got doctors and nurses mostly running the services. And we've got different grades of doctors, just like in America, consultant would be your senior doctors who are clinicians, and that's me. I'm a clinician essentially just doing a little bit of research. The research for this project is really to, because we're a new service, we want to show that we're effective to make sure we keep our funding in the economic pressure that's around the UK.

Dr. Josh Berezin (05:06):

And so maybe also a more specific question is around people who are diagnosed with borderline personality disorder. So outside of the program that we will talk about in a minute, what is the basic care that people with borderline personality disorder receive in the UK and who does this work for and who does it leave out?

Dr. Simon Graham (05:31):

When I started work in the NHS 25 years ago, people with personality disorder probably weren't getting any treatment at all actually. And around the early 2000s, there was actually a national initiative to make the treatment of personality disorder something that the trusts or healthcare providers had to

engage with. It was a policy paper called No Longer a Diagnosis of Exclusion, and that was happening just around the time that psychotherapies were beginning to be developed to treat people with personal disorder. So in America you'll be very familiar with DBT, dialectical behavior therapy, and here in the UK we had a parallel intervention called mentalization based treatment. So slowly there was the beginning of a change in and less nihilism around working with personality disorder. At that time, I became a consultant and our therapy service here in Liverpool started to bring on board those new modalities of therapy.

(06:33):

So that was happening here in Liverpool, but was happening all around the UK, services were beginning to start to do therapy for personality disorders, specifically with a good evidence base. A little bit later came a further evolution with something called structured clinical management. And I'm not sure whether that's a term that people in America are familiar with, but the randomized control trials from DBT and MBT had a control arm of best clinical practice, and the studies seemed to show that people were getting better from best practice, and that became called structured clinical management. And so we started to see therapies helping people with personality disorder, but then shifting to work with more complexity and with staff who weren't therapists. And that became the grounds that we started to develop some of our extended services here in Liverpool. Something else was happening here in the UK.

(07:32):

The central NHS body recognized that there weren't really any good models of treatment for personality disorder. So commissioned 16 pilot sites and they all developed very different models. And when they published the outcome of those new models of service, myself and some colleagues went to visit a couple, and we took the learning from those visits to create what we thought would be a good service by taking one idea from one place, another idea from another place. And we put those ideas together into what's become our range of services here at Spring House.

Dr. Josh Berezin (08:10):

So maybe that's a good segue into talking a little bit about what the programs were that you ended up designing. And also I think some of the context around, both of you talked about in your backgrounds working with people who were in inpatient settings. I think that is, from what I gather, also an important aspect to the development of the program, the programs that you did put together. So what was the context and what did you do in what you ended up describing in the paper?

Dr. Simon Graham (08:40):

So you're exactly right, Josh. For different reasons we realized that as a psychotherapy service, we had to start expanding our case load away from just helping people in the therapy. And I might just quickly cover some of the drivers for that change. First of all, we've got the growing evidence base of effective psychotherapies that were around, but the trust here in Liverpool also had some SUIs or what we call serious untoward incidents, essentially some suicides. And that meant there was an external criticism of the lack of services here in Liverpool that our trust wanted to respond to and develop better services. It was also around 2014, we were in the midst of a financial crisis after the banking disaster. And so money coming forward to the National Health Service was getting quite restricted, and our senior managers in the trust said, we're open to ideas about any cost savings that you clinicians can generate.

(09:43):

And that led me to slightly foolishly, but bravely said, I think I can see a way that we could help with that because I can see that we're spending a lot of money looking after people on inpatient units, but we

don't have any community services. And if we were to reconfigure where the money was spent, we could develop better services. One last thing that might be helpful to mention is due to and a change in the way the psychotherapy service was set up, I was asked to take on the role of being a gatekeeper for patients who were sent out of area. And I don't know whether this is something that happens in America, Josh, but here in the UK, when patients get stuck on local inpatient systems, there's often a turn towards the private sector as though they can find some miraculous cure for people with personality disorder.

(10:35):

So that we've got a system here of teams on the inpatient units getting quite hopeless at times, and then sending what they perceive difficult to help patients into the private sector. Often it's a geographical distance and we call that an out of area treatment. Does something similar like that happen in America, Josh?

Dr. Josh Berezin (10:55):

Well, there's each locality is a little bit different, and I'm most familiar with services in New York City and New York state where it is more of a patchwork. So the public and private hospital systems are operating a little bit more in parallel for general inpatient psychiatric care. And then there are state psychiatric centers who treat people who don't get better on regular inpatient units. And then there is a private system of more residential care that's not really reimbursed by any of our government institutions that tend to be quite expensive, particularly for specialty care for people with borderline personality disorder. And then what happens in other states I'm not as familiar with, but I assume it's relatively similar.

Dr. Simon Graham (11:58):

So eventually we persuaded our commissioners to reinvest money locally in some local community services rather than sending a few people out of area at great expense. To begin with, we had conventional psychotherapy service that was largely based around psychodynamic therapy. So we do group and individual psychodynamic therapy and then extensions from that cognitive analytic therapy, which is a really popular similar form of therapy here in the UK. But we also had a family therapist, but we weren't touching people who wouldn't engage in therapy. So after visiting Leeds, we started to develop a case management service, and that was just a couple of nurses actually who would work alongside us taking on a caseload of 10 patients each.

(12:50):

And the primary focus was to reduce admissions. So we had six people who'd been sent away all over England and locked away for many years, and no one was reviewing them. And we somewhat heroically, we thought, well, we'll give a go at looking after them. So we brought them back, found them places to live in supported accommodation, and then they became the people who were under case management and Kathy and her colleagues had psychological skills that they would use. We'd probably start off with a bit of a formulation, a psychological formulation to try and understand their behaviors. But it was really a process of slow stabilization back to living in the community way from being in a hospital setting.

Ms. Kathy Curtis (13:33):

So we work with people on a two-year pathway under case management. So we might take the place of somebody who otherwise would've been managed in the community by a community psychiatric nurse who may have 20, 30 patients on their caseload who wouldn't have the time to use, I guess, enhance therapeutic skills, working with families, working with accommodation providers, spending that time to

manage the system around the individuals. So our caseload is reduced, so we cap it usually at around 10, which means that we've got more time to work with the patients with the most complex need. The two-year path where the first year is usually stabilization like Simon says, and then we try to steer them to something more therapeutic if that's within their capabilities.

(14:28):

Part of our role is also as a conduit to getting them involved with the day service and the safe service that we mentioned earlier. She doesn't always happen, but after the two-year period, if we've managed to do that, the attachment is moved away from the case manager. And we think about attachment quite a lot when we work with our patient group. And that attachment is passed on to the day and the safe service, which is moving now towards a therapeutic community.

Dr. Josh Berezin (15:04):

So the folks that you're working with, they are like, they're not engaging in traditional psychotherapy when you first meet with them. They're not going to a four-time-a-week DBT group. They're not going to somebody who's providing mentalization-based therapy.

Ms. Kathy Curtis (15:22):

Yeah. They wouldn't have the skills to do that because the patients that we take under case management have the most complex needs and usually the most bed days in hospital or attendances, A&E. So all of those features, which would mean that they're very pre-consimplative when it comes to therapy.

Dr. Josh Berezin (15:43):

So this is what's so interesting to me about the project and the paper is that it's really filling this huge gap. I think that we often, at least in the states, and I think in the UK too, is our answer to how can we provide better treatment is well go to DBT, get somebody into DBT treatment or whatever, pick a different evidence-based modality, because DBT, as you mentioned, is not the only one. And then the person is like, I don't want to do that. I'm not going to go to that. And then we have nothing in between. And this seems really filling that gap and is like, there is something else we can do. We can provide clinically informed case management as an initial step to provide some stabilization and hopefully hook up into services. Does that resonate with you?

Dr. Simon Graham (16:37):

That's exactly what we're doing.

Dr. Josh Berezin (16:40):

And besides that, you've also alluded to day services as well and a crisis service as well. So maybe you could flesh that out just a little bit for us as well.

Dr. Simon Graham (16:51):

We got going with just a few nurses in our case management team, but a little bit later, a little bit more funding came along from the trust and we'd always have the ambition of setting up a day service. And we weren't really sure that patients would engage in psychotherapy as part of a day service. So we kept it to just a social therapy model, and it would be about three groups a day, seven days a week into the evening and over the weekend that we would put on things, there'd be recreational groups like walking

and sports groups, but there'd be psychological education groups. There'd be activity groups like sewing and knitting. There'd be television watching groups or film watching groups and.

Ms. Kathy Curtis (17:34):

And some trips, a camping trip.

Dr. Simon Graham (17:37):

Yeah-

Ms. Kathy Curtis (17:37):

... camping trips.

Dr. Simon Graham (17:38):

We started a yearly camping trip with the service users, and we have regular events where we go to the theater or to zoos on trips. And the idea is, is that we've slowly built a community. So rather than patients attaching to the wards or to A&E, they attach to our day service after they've attached to the case managers. And we run the social therapy service on the principles of a therapeutic community. Now in the UK, therapeutic communities have had a long tradition since World War II when they were a way of getting soldiers back to fight in the war effort, a way of getting agency and people back into the war effort. There's been a long history of having therapeutic communities in the UK, but in the economic crisis, all our national therapeutic communities got closed down and it's been left to local regions to set up smaller version. So we were very happy to have an opportunity to recreate a social therapeutic community, which is what we did. Anything you want to bring in about our social therapy, Cath? Because you've been involved in that, haven't you?

Ms. Kathy Curtis (18:51):

Yeah. Social therapy was very well-used by service users. I think there was a tendency with some service users to use only the social groups, the fun groups, and less inclined to engage in the psychological groups, but they were both very well attended. It's also a small staff pool as well. So the same pool of staff that run the groups, they also run the safe service and the crisis lines. So if people ring in crisis or for a support, they're familiar with the staff because if they're attending the day service, it's the same staff in both teams.

Dr. Simon Graham (19:32):

With regard to our crisis service, it's the same staff as Kathy's mentioned, but we wanted to have our own bespoke crisis service, smaller group of staff who the service users get to know really, really well, rather than going to A&E and seeing a different practitioner repeatedly, people who'd got skills in validating crisis rather than patients feeling rejected and passed and sent on their way. They offer face-to-face reviews, crisis telephone calls, tech support, but they're also trained to deliver brief psychological interventions so that we can quickly respond to crises that are popping up, no waiting lists, no assessment for therapy. We do a brief crisis therapy intervention, and that's based on some models of therapy here in the UK, one called psychodynamic interpersonal therapy. And we combine that with a formulation that's based on cognitive analytic therapy, all delivered within five sessions. And then subsequently the staff have been trained in EMDR and narrative exposure therapy. So we can add in trauma-based therapies as brief interventions for people in crisis.

Dr. Josh Berezin (20:44):

Another thing that I really love about this is that all of these interactions are therapeutic. There isn't a connection with the program that isn't geared towards something that is a clinical intervention or a therapeutic intervention. I bet the movie group has a lot of therapeutic value to it, and the crisis interaction is not just solving the crisis, but the interaction with the person on the crisis line is in fact itself an opportunity for a different mode of interaction, a different mode of attachment, a different way of connecting, and then having to get off the line with somebody. So I would imagine that that is a real benefit of having everything geared towards the same people, the same population.

Ms. Kathy Curtis (21:35):

We also have an acceptable behavior policy, so people who use the service have to engage in a program of readiness. So we don't just bring people in who are raw and who might not know how they expect it to behave or understand the impact of their behaviors. On others, there's a readiness program, and if they complete the readiness program, then they're aware of the acceptable behavior policy and they're integrated into the service. So like you say, the movie group is about socializing people and creating a safe space because it's understood and respected that the building and the groups are safe at calm places to be, which is the opposite to the psychiatric ward that they might have been used to.

Dr. Josh Berezin (22:31):

Yeah. And you've also created a frame that again, is not just about we have to make sure you're safe here, which is an obvious benefit to having a frame, but the frame itself saying this is what behavior is expected in the program, that in itself is another kind of therapeutic intervention. So you can't get away from a therapeutic intervention in this.

Dr. Simon Graham (22:57):

No, that's right, Josh. Observing the system as a clinician over many years, what I see is lots of people having assessments but no intervention. And as a therapist, I see the value of an intervention and we want every kind of contact to have some interventional aspect to it. So just picking up on what Kathy was saying, so if people start to act in a non-social way and start to get into conflict with each other, what happens is we notice that and we call a special community meeting where all the service users are invited and all the staff members, so we can have 20 people in a meeting, and we discuss the incidents and reflect upon it, and we take learning from it, and we put responsibility for people to change in it, so we police it together.

Dr. Josh Berezin (23:46):

So that's maybe a good segue to some of the results, because the paper is presenting some outcomes from an evaluation. So maybe you could just give, what are a couple top-line findings that you would want people to take away from the evaluation?

Dr. Simon Graham (24:02):

I think our take-home messages would be that people with personality disorder don't need to be hospitalized for long periods of time and certainly don't need to be sent out of area across the country. The reasons for that is, we've not mentioned it, but from our perspective, we can see a lot of iatrogenic harm occurring through those experiences. By providing a local community service, we can reduce those hospitalizations so you can end up with a win-win. There's a clinical win in that service users have been

helped to be stabilized and integrated back into society. There's also a huge financial win, and that's really, really important in the healthcare setting where resources can be quite limited.

(24:47):

So our paper had a partial cost analysis that was showing that it was much cheaper to set up our local service than continue with the current system or the old system where people were having lots of inpatient admissions and sent out of areas. So we were showing some good cost benefits really. There was a little bit of clinical shunt, obviously people who were in hospital and continually when they came out into the community, they were using A&E a little bit. So we did see some small increases in A&E-

Dr. Josh Berezin (25:18):

And sorry, A&E is?

Dr. Simon Graham (25:20):

Thank you. Thanks, Josh. I think you might call it the emergency room.

Dr. Josh Berezin (25:20):

Got it.

Dr. Simon Graham (25:23):

Or the emergency rooms. Yeah.

Dr. Josh Berezin (25:25):

We do.

Dr. Simon Graham (25:26):

We call it accidents and emergency sometimes. Yeah. Although I think we are becoming more American in our terminology. As you might expect, there's a little bit of increased contact of other services because our own crisis service closes down in the evening. And so overnight our service users or patients will use other community services.

Dr. Josh Berezin (25:49):

And just to give people a sense, what are some of the numbers that you present in the paper in terms of some either the cost benefit or the reduction or increase in service?

Dr. Simon Graham (25:57):

Yeah, no, thanks Josh. So after 12 months of case management, the reduction in use of hospital was around 49%, like 50%. After three years, that was down to 75% reduction, so quite significant. And here in the UK a day in hospital for a patient costs 500 pounds. So those reductions were very helpful to the system and allowed for the funding of our community service. And out of area treatment, when someone's sent to live in a hospital in a different part of the country, they're in the region of 250,000 pounds a year. So to reduce those and not have other people going out, there's a big financial benefit to the trust. Perhaps one of the things that was most surprising for me, and I hadn't anticipated this, but my senior manager reported back to me when I met him was that by creating a service for personality disorder, our own inpatient services began to have flow. For the first time in a long time we were not

sending any patients with any diagnosis out of area, and we were able to consume our own clinical need locally.

(27:10):

And that was really appreciated by the trust as a whole at the time we set up.

Dr. Josh Berezin (27:16):

So it sounds like you were able to show in the evaluation that the program was in fact achieving its goals and successful, and we definitely point our listeners to the paper for more details on that. As we wrap up one question that came up for me is a little bit around your experience as clinicians and providers, particularly around the counter-transference that comes up in working with people with borderline personality disorder. So I'm just wondering how you all either dealt with that in your own personal practice or that the program dealt with it.

Ms. Kathy Curtis (27:55):

I think obviously counter-transference is real and we name it and we talk about it. I think in this service, what's quite unique is that the care is based on a formulation, which helps with counter-transference because we're continually thinking about the patient from the point of view of their formulation. And obviously that helps to elicit a lot more empathy from practitioners. And we're also very well supervised. Our supervision for staff is unlike anything I think anywhere else in the trust. So we have regular clinical and managerial supervision with doctors in the team.

Dr. Simon Graham (28:37):

We would each week, the case managers, but also the staff in the day and crisis service have a space to talk about their therapeutic experience from a clinical level where we process this, we try and understand what's the meaning of patient's behavior. And so we learn to tolerate it.

Ms. Kathy Curtis (28:57):

And to understand the counter-transference that we feel.

Dr. Simon Graham (29:00):

So we offer a lot of supervision. We've also done a huge amount of staff training, haven't we? And most members of staff are trained up in several models of therapy, which they can draw those skills from. And I think we also have a very clear rationale for treatment that leads to consistency. And we're all on the same model. We all know what's going to happen. We all know the kind of response our service would offer. And so you have a lot of support within the team for our approach.

Dr. Josh Berezin (29:35):

And then, Simon, you were also talking a little bit offline about some of the more institutional support that your teams had received.

Dr. Simon Graham (29:41):

Yeah, no, thanks for asking me to talk about that Josh. As a parallel initiative to developing the service, we thought it was important to provide some psychological containment to the staff within our service, but across the whole trust when working with people who diagnosed with personality disorder. So we developed a policy that was informed by best evidence practice and guidelines. And essentially it was a

document that said, it's okay to take positive risks with this patient group because if we don't, we are potentially causing more harm through long, unhelpful admissions. And in order to ensure that staff felt contained, we got our chief executive and our senior leadership team to sign off on that, and they were very happy to, and we also got service users to input into that document to say they agreed that this was an appropriate way forward. And that policy sits alongside us saying our approaches is a good thing to do that feels containing to know that trust supports this approach.

Dr. Josh Berezin (30:46):

And I will wrap up with one final question is, are there other ways that recipients have been included either in the development or the running of the program in terms of their input?

Dr. Simon Graham (30:57):

Yeah. Yeah, that's important to explain Josh. A therapeutic community and our social therapy service is a form of therapeutic community, involves a huge amount of service user cooperation and participation. So we have a regular weekly meeting that involves the service users helping us plan how to run the service, getting involved in research projects, getting involved in different forms of communication, such as making videos, making websites so that patients can book on for things. So a huge amount of collaboration is involved. We've done some other bits of research that have been led by service users and they've been focus groups on service users. So for just as one brief example, we got together the service users who had had very long out of area placements and got them to feedback what it was like. And then we wrote that up and then that got taken to a conference as a poster. So very, very involved in everything that we do.

Dr. Josh Berezin (31:59):

Well, that seems like a good place to wrap things up, and I just wanted to thank you so much for the paper and also for joining me today on the podcast. It was a real pleasure.

Dr. Simon Graham (32:09):

Thank you, Josh, for giving us the opportunity to talk about our service. And from all the staff here at Spring House, can we say thank you?

Ms. Kathy Curtis (32:17):

Thank you, Josh.

Dr. Josh Berezin (32:18):

You're welcome. That's it for today. Thanks to Aaron Van Dorn for mixing and editing and Demery Jackson for additional production support. We invite you to visit our website, ps.psychiatryonline.org, to read the article we discussed in this episode, as well as other great research. We also welcome your feedback. Please email us at psjournal.psych.org. I'm Josh Berezin, and we will see you next time.

Speaker 4 (32:40):

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