Brief admission for patients with BPD: development of a self-management intervention to prevent or overcome crisis

For reasons of consistency within this thesis, some terms have been standardized throughout the text. As a consequence the text may differ in this respect from the articles that have been published.

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Brief admission for patients with BPD: development of a self-management intervention to prevent or overcome crisis

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Chapter 1

General introduction

In the past, the focus of mental health care organizations in the Netherlands was on social psychiatry. Starting in the 1970s, however, crisis intervention models were introduced with the aim of treating psychiatric crises within the community and thereby avoiding hospitalization or reducing the duration of hospitalization when it proved necessary (Weisman, 1989). In 1983, the RIAGG (Regional Institutions for Community Mental Care) became legally obliged to deliver 24 hour crisis services. Despite this, admission rates for Dutch mental health care hospitalization rose from 19,000 in 1979 to 28,000 in 1991 (Wiersma, 1994). Moreover, long admissions for patients with a borderline personality disorder (BPD) in particular were found to have clearly negative side effects, including regression and increased acting out behavior. Day treatment models were subsequently developed in an attempt to bring mental health admission rates down and reduce the need for prolonged admissions. During this same period, the so-called Brief Admission was developed to provide patients in day treatment with the possibility of a short admission when in crisis or crisis is looming (Veldhuizen et al., 1988).

The Brief Admission proved to be a good answer for the problem of long-term admission to Dutch mental health care. Brief admissions are widely used in the Netherlands today, but their exact use and critical components have yet to be studied systematically. As a result of this lack of documentation, clinics deliver Brief Admissions in a wide variety of manners with differing quality of care and outcomes as a consequence. The *best* way to deliver a Brief Admission in the opinions of patients and clinicians is also still unknown. The critical components, outcomes that can be expected, and research foundation for the use of Brief Admission as a crisis intervention also have yet to be clarified.

In this General Introduction, the characteristics of patients with a BPD are first described and then we will specifically consider their particular vulnerability for crisis. The delicate balance between autonomy and dependency within the therapeutic relationship will also be discussed, followed by a discussion of the pros and cons of offering protection versus treatment. The state of the art with regard to the use of brief admissions for purposes of crisis intervention prior to the start of the present research will then be described, followed by an outline of the objectives of research reported in this dissertation and a short overview of the chapters of the dissertation.

Characteristics of Borderline personality disorder

BPD is characterized as having a pattern of unstable and intense interpersonal relationships, affective instability (including intense anger at times), poor impulse control, and self-mutilating behavior (DSM-IV, 2000). The etiology of BPD is best explained as a combination of genetic and neurobiological vulnerability combined with possible childhood trauma, abuse, or neglect leading to deregulated emotions,

distorted cognitions, social skills deficits, and limited adaptive coping strategies (Herman et al., 1989).
When Grant et al. (2008) performed a nationwide study among 34,653 adults in the USA to estimate the prevalence of BPD, a lifetime prevalence of 5.9% was found (99% CI: 5.4–6.4). In a systematic sample (N = 218) from an urban primary care practice, a lifetime prevalence of 6.4% was found. This shows the prevalence of BPD in primary health care to be *high* (Gross et al., 2002). Such a diagnosis is found in 10% of all psychiatric patients in community care, moreover, and 20% of patients admitted to a psychiatric hospital (Ingenhoven & Van den Brink, 1994; Paris, 2010). Furthermore, patients with a BPD are regular users of psychiatric emergency services and have been found to consume high levels of health care and social resources (Paris, 2002).

BPD is associated with considerable mental and physical disability, especially among women (Grant et al. 2008). Patients with a BPD have been found to have significantly more impairment at work, within their social relationships, and in leisure time activities than patients with an obsessive-compulsive personality disorder or a major depressive disorder. Impairment of social relationships is generally most noted among patients with a personality disorder while patients with a BPD have *also* been found to receive a greater amount of treatment than patients with a depressive disorder and patients with other personality disorders (Skodol et al., 2005). BPD is further associated with high rates of self-destructive behavior, and a 10% lifetime suicide rate is reported in the literature (Oldman, 2006; Paris et al., 2001). In a prospective study of a sample of borderline patients at 6-year follow-up, however, a considerably lower rate of completed suicide was found, namely 3.8% (Zanarini et al., 2005).

Borderline Personality Disorder and crisis
Due to the characteristics of the disorder, patients with a BPD are very vulnerable for the experiencing of a crisis (van Luyn, 2014). Finding oneself in crisis and the experience of feelings of abandonment, despair, and suicidality often occur. Suicidal ideations, acting out, impulsive action, impulsive reactions, and self-harm are also symptoms of the disorder and present during a crisis (Linehan, 1993). These symptoms have a large negative effect on the social and relational functioning of the patient with a BPD. Suicidal behavior, intended to alleviate emotional pain, can clearly endanger the life of a patient (Bateman & Krawitz, 2013).
Linehan (1993) describes four stages of treatment for patients with BPD. In stage 1, when the patient's symptoms are most severe, the behavior of the patient may be out of control: they may attempt suicide, induce self-harm, use drugs and alcohol to an extreme, and engage in other types of self-destructive behavior. The first priority in treatment, according to Linehan (1993) then, is to target crisis situations involving life-threatening behaviors such as all forms of suicidal and non-suicidal self-injury, suicidal

ideation, suicide communications, and other behaviors engaged in for the purpose of causing bodily harm. Therapy-interfering behavior, which entails any behavior that interferes with effective treatment and possibly leads to treatment drop-out, is targeted next.
Treatment drop-out due to crisis nevertheless remains a problem for patients with BPD. In a study by Nadort et al. (2009), schema therapy plus extra phone support was compared to schema therapy without extra phone support. Dropout was 22% in the intervention group compared to 20% in the control group. In two trials comparing Dialectical Behavior Therapy (DBT) with Treatment as Usual (TAU), dropout rates of 25% versus 59% (Linehan et al., 2006) and 37% versus 67% were found (Verheul et al., 2003). However, during a trial, treatment conditions are optimal and there tends to be a strong focus on the prevention of dropout, which means that DBT dropout rates more similar to those for TAU can be expected in daily practice.
When treatment must be discontinued due to crisis, treatment progress is obviously hampered and the goals of treatment may therefore not be met, resulting in a vicious circle of help seeking and help rejection. Adequate crisis management is therefore *essential* for the successful treatment of BPD. In addition to being dangerous for the life of the patient, a burden on the family, and a problem for the children of the patient, psychiatric crisis can disrupt any progress being made during long-term — often specialized — community care treatment (Clarkin, Yeomans, & Kenberg, 2006). A Cochrane review (Borschman, et al. 2012) on the evidence for the effectiveness of crisis interventions for patients with BPD found no evidence for the effective management of acute crisis in patients with a BPD. After this review, the results of a randomized control trial were reported by Borschman et al. (2013). The joint crisis plans of patients with a BPD were found to have high face validity, but no evidence of clinical efficacy was found. The authors describe the importance of having a crisis plan that is fully integrated with the other components of treatment as opposed to a one-off intervention offered to the participants in the trial reported on.

The need to maintain a balance between autonomy and dependency within the therapeutic relationship

During treatment for a BPD, a delicate balance must be maintained between the provision of support to enhance autonomy on the part of the patient and the provision of opportunities to connect within the therapeutic relationship, which can give rise to dependency at times. In the guidelines from not only the American Psychological Association (APA, 2010) but also the National Institute for Health and Care Excellence (NICE, 2009) and the National Health and Medical Research Council (NHMRC, 2012), the development of autonomy and promotion of individual choice are mentioned as key factors in the treatment of BPD. The NICE guidelines (2009) further indicate that patients should be actively involved in finding solutions for their problems, *even when*

they are in crisis. According to this guideline, patient involvement in the finding of a solution for a problem (or problems) allows them to gain experience with the handling of crisis and develop the autonomy needed to make decisions during times of crisis (or pending crisis). The patient with a BPD nevertheless needs help with the development of such an ability due to, among other things, their particular vulnerability for crisis, as discussed above.

The dynamics of the need for protection versus treatment

There is further a difficult dynamic present in the treatment of patients with BPD between the offering of protection versus explicit treatment. When acute suicidal behavior and other destructive behaviors occur, the life of the patient is in danger and protection is called for. Patients with a BPD are typically in need of admission to a mental health facility to help them cope with the acute risk of suicide or occurrence of risky behavoirs but also sometimes for a respite/time-out from daily life stressors.

Unfortunately, however, the unplanned and/or long-term hospitalization of patients with a BPD in a general psychiatric setting has been shown to have limited value and even negative side effects at times: regression, need for repeated admission, or nonrecovery from chronic suicidal ideations following discharge (Paris, 2004). Repeated admission to a psychiatic hospital or other mental health facility can also interrupt ongoing psychological treatment and impede efforts on the part of the patient to develop the autonomy needed to cope with their BPD and the occurrence of a crisis (or a pending crisis). Acceptance of the presence of chronic suicidality without direct protection is thus needed at times to sustain psychological treatment and train the skills needed to cope with crisis. Longitudinal research indeed shows that most such crises occur during the first year or years of treatment and that the patient generally stabilizes as treatment and skills training progress (Gunderson et al., 2011). The dynamic of protection versus treatment will thus vary depending on the phase of treatment and the patient. During the course of treatment, the focus will shift from largely protection treatment more and more to training — in keeping with the patient learning to effectively handle or prevent crisis. In other words, intervention (or protection) is needed with a focus on promoting autonomy (training/treatment) even when the patient with a BPD finds him/herself in crisis. Stated differently, the patient needs to be given an opportunity to recover from a crisis by choosing an approriate action even when extremely vulnerable and in need of help.

Is Brief admission perhaps an answer?

To summarize: Patients with BPD will experience crises, but disruptions of outpatient treatment by lengthy admissions should be avoided whenever possible due to 1) the negative side effects and 2) the need to develop patient autonomy and sufficient insight to deal with crisis or possibly prevent it. In the Netherlands, brief admissions

were initially adopted to deal with the vulnerability of patients with BPD and to avoid lengthy admissions. Brief Admission as a crisis intervention was rapidly adopted across most mental health facilities in the Netherlands and has now been used for decades. A sound research base for the use of such admissions is nevertheless lacking and the use of Brief Admission for purposes of crisis intervention or prevention has remained largely unstandardized. The reasons for the use of a Brief Admission are clear, but what to do as part of such a Brief Admission is still unclear.

What constitutes a Brief Admission today

Brief admission refers to a clinical admission to a psychiatric hospital ward or mental health facility for a period of 1 to 5 nights. Patients must first formulate a treatment plan together with their community mental health nurse, and this treatment plan stipulates the maximum number of brief admissions allowed per month or three months. The treatment plan is arranged when the patient is not in crisis and will be provided by hospital psychiatric wards or other mental health facilities where nurses are available to care for such patients. The Dutch Multidisciplinary Guideline for Personality Disorders (2008) recommends Brief Admission as a treatment and crisis management approach for patients with a BPD, but it does not stipulate how the intervention should be carried out in practice. Given the demanding, claiming, attention seeking, and sometimes manipulative behavior of individuals with a BPD, mental health care professionals often regard such patients as “difficult patients” (Koekkoek et al., 2006). It is thus important that the attitudes of both patients *and* professionals be examined in connection with the use of Brief Admission for crisis intervention and prevention purposes but also as we strive to identify the critical components for the use of a Brief Admission from not only the perspective of the patient in crisis or pending crisis but also the mental health professional.

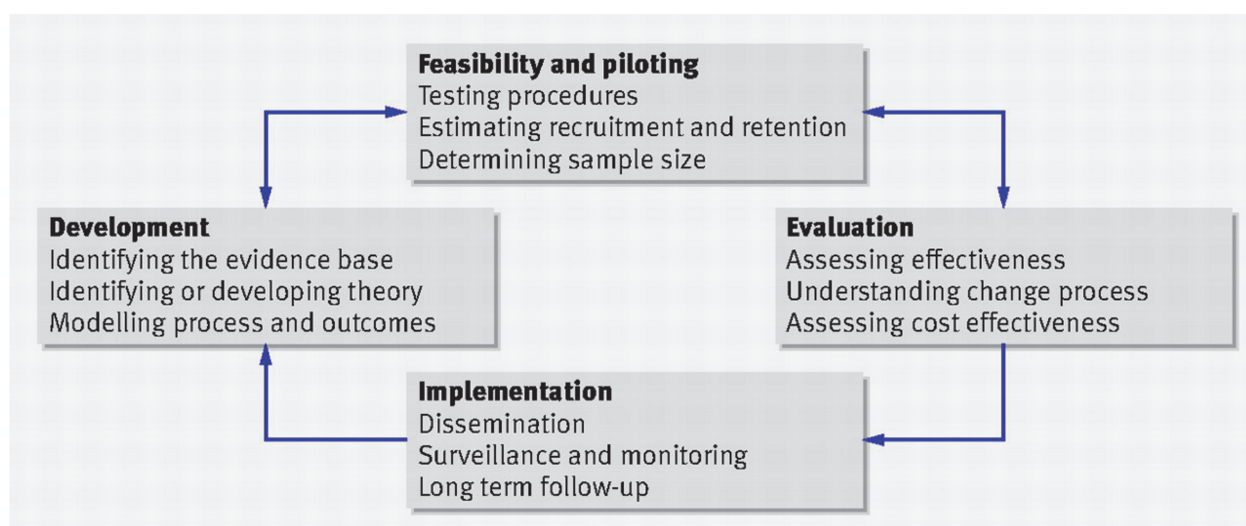
A complex intervention

Brief Admission used for crisis intervention can be considered a complex intervention, as described by the MRC framework for the development and evaluation of complex interventions (Craig et al., 2008) with several interacting components including the creation of a brief admission plan, the patient being admitted for only a short period, nurse-patient interaction, the tailoring of the actions of nurses to the condition of the patient, and so forth. The *complexity* of Brief Admission when used for crisis intervention stems from the number and difficulty of the behaviors required of the nurses delivering the intervention. Every patient with BPD is different, and different symptoms can be experienced by the patient when in crisis. Nurses thus need to adjust their attitudes and interventions to the individual patient and the level of patient functioning.

The MRC framework (Craig et al., 2008) has called for the development of complex interventions based on sound theoretical and experiential research. Fortunately, most complex interventions are developed in such a way that they can be tailored to the local circumstances of organizations but use the same outcome measures. This uniformity is important in light of the fact that Brief Admission is offered by a wide variety of mental health care organizations and thus in different facilities with different cultures and policies.

Currently, the intervention lacks a sound evidence base. Despite being used for decades, we know very little about the working elements of Brief Admission, just how Brief Admission works, or what outcomes can be expected when Brief Admission is put to use. This implies that, in relation to the MRC framework (see Figure 1), exploratory work is needed to guide the development of the intervention and provide a framework for understanding the utility of Brief Admission for crisis intervention and prevention (see the "development" box in Figure 1).

Figure 1. Key elements for the development and evaluation of Brief Admissions as crisis intervention



Aims of this thesis

The overall aim of this thesis was to develop a research base for the use of Brief Admission as a complex intervention to promote the self-management and growth of autonomy among patients with a BPD in accordance with the MRC framework.
The following specific research objectives were formulated.

1. To identify key components of Brief Admission as a crisis intervention for patients with a BPD and the evidence base for these components.
2. To describe the experiences of BPD patients with brief admissions.

3. To better understand the potential contribution of Brief Admission to the ongoing treatment process.
4. To describe the similarities and differences found to date in the protocols provided by organizations using brief admission as an intervention for patients with BPD.
5. To obtain consensus among mental health professionals on the relevance of the components of Brief Admission as a crisis intervention for patients with a BPD.

Outline of this thesis

In this thesis, research for the “development” box of the MRC framework for the management of BPD was undertaken (see Figure 1). Existing evidence was identified via the conduct of a systematic review of the literature. Thereafter, specific studies were undertaken to clarify the design of Brief Admission as a crisis intervention and identify the most relevant components.

The thesis is composed of 7 chapters. In **Chapter 2,** the conduct and results of the literature review are described. The purpose of the review of the available literature was to identify the relevant components of the use of brief admissions to help patients with a BPD. Articles in all languages were considered and included for initial consideration, provided a discussion of BPD and Brief Admission was clearly apparent (i.e., Brief Admission interventions or components of Brief Admission as an intervention were discussed). Quantitative studies, qualitative studies, reviews, and practice reports were included. This systematic search produced 88 admissible abstracts, which were then examined along with the article titles by two researchers independent of each other. A total of 24 articles were selected for closer examination. No relevant randomized controlled trials were found. Of the 24 articles, 14 had to be excluded because they did not address patients with a BPD or did not describe a Brief Admission intervention. In the end, thus, 10 articles met the inclusion criteria for the review: 5 quantitative studies, 1 mixed-methods study, and 4 qualitative studies. Content analyses were then conducted on the components of the interventions described in the studies included in the review.

The focus in **Chapter 3** is on the experiences of patients suffering from a BPD with the use of a brief admission for crisis management. An interview study using the descriptive phenomenological methodology of Giorgi (2008) was conducted for this purpose. The inclusion criteria for this phenomenological study were a diagnosis of BPD according to the Diagnostic and Statistical Manual of Mental Disorders-IV criteria; experience with brief admission; and sufficient understanding of the Dutch language. A total of 16 female patients and 1 male patient participated in the study. A qualitative, in-depth interview was conducted with each of the 17 participants. The interviews had a duration of 45–75 minutes and were guided by an *aide memoire*, which was based on

the review of the literature and clinical experience (Helleman et al. 2014). The *aide memoire* consisted of key words, which were used together with a list of research questions to guide the interviews. The interviews were initiated by asking the participant to *tell me about your experiences with the brief admission intervention*. The participants were then asked to describe their experiences in greater detail. Data saturation was reached when no new meaning units could be identified for the interviews, which was after the conduct of interviews with 15 participants.

In **Chapter 4**, I present the results of a longitudinal case study in which the use of brief admissions by a single patient across a period of seven years is described to illustrate how brief admission to a hospital psychiatric ward can work in actual practice. The patient suffered from a BPD and a Complex Post Traumatic Stress Disorder. Multiple data sources were considered by conducting semi-structured interviews with: the patient, the patient's spouse, the patient's psychiatrist, a ward nurse, and a community psychiatric nurse. Additional data was retrieved from the patient's medical records. And four phases in the patient's treatment could be identified: crisis, treatment for PTSD, treatment for BPD, and recovery.

In **Chapter 5**, the results of a descriptive study of the organization of brief admissions in the Netherlands are presented. The similarities and differences in the protocols provided by organizations using Brief Admission as an intervention for patients with BPD were examined for this purpose. The content of 41 protocols for the use of Brief Admission as an intervention at 33 mental health care facilities was analyzed. The initial content analysis was conducted using a list of 22 items identified on the basis of previous two studies (i.e., the review and interview study).

In **Chapter** 6, the results of a Delphi study conducted to gain consensus on the key components of the use of Brief Admission as a crisis intervention for patients with a BPD are summarized. The study was conducted during a four-month period in 2015 and included 88 Dutch experts. In the end, 41 of the experts completed the entire Delphi procedure: 6 doctors, 24 clinical nurses, and 10 mental-health nurse practitioners and/or mental-health nurse researchers. The participants were asked to rate the relevance of 90 components of Brief Admission for the management of a crisis involving a patient with a BPD. Consensus in the form of at least 70% agreement among the experts on the relevant components of a Brief Admission for crisis management as was obtained in two Delphi rounds.

Finally, in **Chapter 7** the main findings of the studies conducted to gain insight into the use of Brief Admission for purposes of crisis management are summarized and discussed. Suggestions for actual practice and further research are made. And it is

concluded that Gunderson and Links's (2014) theory regarding the manifestation of BPD may shed some light on the occurrence of difficulties with the use of Brief Admission for crisis management and particularly the difficulties characteristic of the contact of patients with a BPD with nurses and other patients.

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Chapter 2

Evidence base and components of brief admission as an intervention for patients with Borderline Personality Disorder: A review of the literature

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Peter Goossens
Aad Kaasenbrood
Theo van Achterberg

Perspectives in Psychiatric Care 2014; 50: 65-75.

ABSTRACT

Purpose: To review the available evidence-based literature on the components of Brief Inpatient Psychiatric Hospital Admission as an intervention for patients with borderline personality disorder.

Design and Method: Systematic literature search, narrative literature review. Content analysis.

Findings: Five key components of Brief Admission as an intervention were identified: discussion of goals; organization of Brief Admission; clear admission procedure; specification of any other interventions during Brief Admission; and stipulation of conditions for premature (i.e., forced) discharge.

Research and Practice implications: Brief Admission can be effectively used to prevent self-harm and suicide in patients with borderline personality disorder. During the Brief Admission psychiatric nurses can support these patients achieving an active coping in dealing with their symptoms.

Borderline personality disorder is the most common personality disorder seen in clinical settings and present in many cultures around the world (APA Practice Guidelines, 2001; Dahl, 1994). Borderline personality disorder (BPD) is characterized by a pattern of unstable and intense interpersonal relationships, affective instability — including intense anger, poor impulse control, and self-mutilating behavior at times (DSM-IV-TR, 2000) — and disturbances of identity and self-direction (Bender & Skodol, 2007).

Patients with a BPD have been found to have significantly more impairment at work, in social relationships, and in leisure activities when compared to patients with a major depressive disorder (Gunderson et al., 2011; Newton-Howes et al., 2008; Skodol, 2002.). A community-based epidemiological study in a sample of 859 psychiatric outpatients in the United States found 9.3% to be diagnosed with BPD (Zimmerman et al., 2005). The median prevalence of BPD in the general population is 1.6% (Torgersen, 2009). Chronic suicidality is a characteristic of BPD. And patients with BPD are high-level users of health care, social services, and — in particular — psychiatric services and emergency hospital services (Chiesa et al., 2002; Paris, 2002.).

Patients with BPD are treated in both community and hospital settings (Cleary et al., 2002). This is done by clinicians including psychologists, psychiatrists, and nurses. Treatment typically starts with community services followed by day care, brief admission, or long admission — with individual and/or group psychotherapy — as needed. Most patients with BPD receive psychotherapy like Dialectical Behavior Therapy (Linehan, 1993), Mentalization Based Treatment (Bateman & Fonagy, 2009), Schema Focused Therapy (Giesen-Bloo et al., 2006) or Transference Focused Therapy (Clarkin et al., 2006). Patients may also need pharmacotherapy, nursing support, crisis intervention to prevent suicide or deliberate self-injury (Cleary et al., 2002), and rehabilitation as well.

The behavior of patients with BPD — including manipulation, self-mutilation, aggression, and noncompliance with treatment recommendations — can challenge the therapeutic relationship. Such patient behavior can impede the efforts of the clinician and give rise to feelings of frustration and anger in clinicians who try to understand the destructive behavior and emotional outbursts of such patients. Negative responding on the part of clinicians can then, in turn, further disrupt patient care (Bland et al., 2007; Koekkoek et al., 2006). Betan et al. (2005) found significant correlations between six countertransference factors evoked in professionals by patients with cluster B personality disorders. The six factors were: feeling overwhelmed/disorganized, helpless, inadequate, special/overinvolved, sexualized, or criticized/mistreated. These countertransference factors can affect clinicians in their ability to maintain therapeutic relationships with patients with BPD. There is a risk for, par example, over involvement were responsibility is taken over from the patient with BPD. This prevents the patient to grow in autonomy and coping skills. Or the risk for abandonment and neglect were as a result the patients' needs are not met.

Given dangerous behavior on the part of the patient and the burden on the clinician, a short interruption of outpatient treatment with a hospital admission in a psychiatric hospital may be necessary at times to protect the patient and relieve the clinician. However, unplanned or long-term hospitalization of patients with BPD in a general psychiatric setting has proven to have limited value and negative side-effects. Regression, repetitive admission, and non-recovery from chronic suicidal ideations following discharge are often the case (Paris, 2004). According to Krawitz et al. (2004), briefer acute admission is now the dominant short-term goal with the promotion of responsibility and empowerment of the patient as the long-term goal. Patients must be given an opportunity to learn to tolerate their feelings and thoughts during a crisis. Krawitz state that clinicians should accept the short-term risk of self-injury and suicidality involved.

The NICE clinical guideline (2009) for Borderline Personality Disorder and the Dutch Multidisciplinary Guideline for Personality Disorders (2008) describe several recommendations on treatment of patient with Borderline Personality Disorder in crisis. The Dutch Multidisciplinary Guideline for Personality Disorders (2008) recommends Brief Admissions as a treatment and crisis management approach for Borderline Personality Disorder. Brief Admission is thus a frequently used crisis intervention in the Netherlands with a duration of maximum three nights, a clear treatment plan and with a maximum number of brief admissions. The treatment plan is arranged by the patient and clinician when the patient is not in crisis. In a similar vein, the NICE clinical guideline (2009) for Borderline Personality Disorder mentions the development of autonomy and promotion of individual choice as key factors for treatment. Patients should be actively involved in finding solutions for their problems even when they are in crisis as this allows them to gain experience with the handling of crisis and to develop some autonomy with regard to the decisions to be made at such a time. Also recommended in the NICE clinical guideline is the development of a crisis plan that outlines those self-management strategies that are likely to be effective and stipulates how to access treatment services when the self-management strategies are not enough.

Despite the recommendation of a crisis plan with a list of possible self-management strategies, no specific self-management strategies — such as brief admissions, are described in the NICE clinical guideline. The Dutch Multidisciplinary Guideline for Personality Disorders recommends the use of a Brief Admission, but it doesn't describe how this intervention should be carried out in practice. Empirical research is lacking, moreover, on the efficacy of the self-management interventions recommended by the guidelines in both the U.K. and the Netherlands.

Given the high vulnerability for crisis of patients with borderline personality disorder, and the high burden on psychiatric services and emergency hospital services, large amounts of research would be expected. With practical interventions and outcomes on crisis interventions for patients with Borderline personality disorder. It is

critical for clinicians to have insight in crisis interventions like the Brief Admission. The purpose of the present literature review was therefore to identify the key components of Brief Admission as a crisis intervention for patients with a borderline personality disorder and the evidence base for the components of Brief Admission. This will further contribute to the development of the Brief Admission intervention.

METHOD

Search strategy

A systematic search of the following databases was conducted for the period January 1985 through December 2011: MEDLINE, CINAHL, PsycINFO, and Cochrane Database of Systematic Reviews. The following Medical Subject Headings were used as search terms: borderline personality disorder AND crisis, borderline personality disorder AND brief hospital*, borderline personality disorder AND prevent*, personality disorder AND crisis, personality disorder AND brief hospital*, personality disorder AND prevent*. The included articles were also used to find additional publications that were judged to be relevant. Two of the authors are experienced reviewers.

Inclusion and exclusion criteria for review

Articles in all languages were considered and included for initial consideration when a discussion of BPD and Brief Admission was clearly apparent (i.e., interventions or components of the interventions). Quantitative studies, qualitative studies, reviews, and practice reports were allowed.

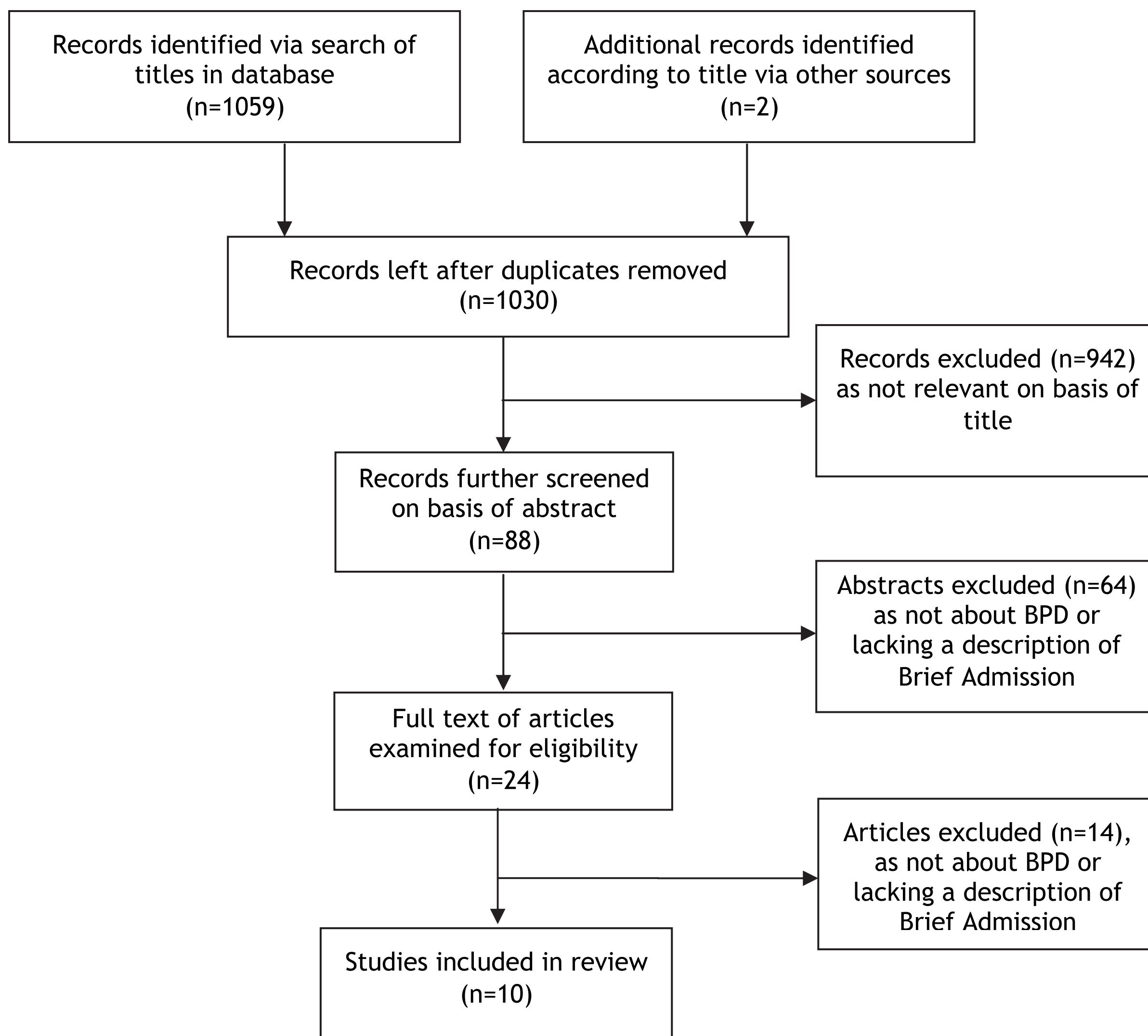
Exclusion criteria were:

- articles published before 1985;
- articles without a description of the use of Brief Admission with patients with borderline personality disorders; and
- articles without a description of components of the Brief Admission.

Selection procedure

In Figure 1, the study selection procedure is presented. Our systematic search produced 88 admissible abstracts. These were then examined along with the article titles by the first and second authors separately. A total of 24 articles were then ordered for closer examination. No relevant randomized controlled trials were found. Out of the 24 articles, 14 had to be excluded because they did not address patients with a borderline personality disorder or did not describe the Brief Admission intervention. In the end, 10 articles thus met the inclusion criteria: 5 quantitative studies, one mixed-method study and 4 qualitative studies.

Figure 1. Study Selection Procedure



Data extraction

Because of the heterogeneity of the study designs, data extraction was obtained through content analyses of the components of the interventions described in the studies. The content of the 9 articles was analyzed in three steps. First, the information gleaned from the initial inspection of the articles was clustered. Then the central themes (i.e., components of the Brief Admission) were identified and described. And finally, the content analyses were peer reviewed and approved by all of the authors.

Data analysis

A meta-analysis of the data from the articles was not possible due to a lack of uniformity in the study designs and outcome measures. To assess the level of evidence and quality aspects of the studies we therefore adopted the approach described by

Polit and Beck (2008) (see Table 1). The criteria were: appropriate choice of study design, adequate sampling, adequate use of instruments, suitable analytic techniques, clear discussion of results and mention of possible limitations. No further exclusion criteria were applied in light of the small number of articles found.

RESULTS

While the literature search was quite thorough, the number of publications in indexed journals was found to be limited. Despite the recommendations of Woods and Richards in 2003 and others in the fields of nursing and mental health since then, research regarding the effectiveness of interventions for people with a borderline personality disorder is still sparse. Some of the studies included in the present review had some major methodological shortcomings. The level of evidence in the studies was low. No randomized control trials were found. According to Polit & Beck (2008), the evidence was Level IV (i.e., single correlational and observational studies) or Level VI (i.e., single descriptive, qualitative, and physiologic studies). A couple of studies are from the early nineties. Given that so little research has been conducted on the Brief Admission intervention for patients with borderline personality disorder, it was nevertheless decided to keep these studies in the review. For details on designs and level of evidence of the outcomes, see table 1. In the following, five core components of the Brief Admission interventions used with patients with BPD are described.

Components of Brief Admission Interventions

Five core components of the Brief Admission interventions used with patients with BPD could be distinguished: 1) discussion of the goal of the Brief Admission with the patient in advance; 2) notation of the Brief Admission procedure in a written treatment or crisis plan; 3) clear understanding of admission procedure and duration of the Brief Admission; 4) description of the interventions used during the Brief Admission; and 5) specification of the conditions for premature discharge. The scope of the included studies and their methodological details are listed in Table 1 and the components of the interventions are described per article in Table 2.

Discussion of goals. Several goals of Brief Admission were mentioned, and the 9 studies agreed on the goals of such admission. The most important goal was prevention of prolonged psychiatric hospitalization because this is typically counter-therapeutic (Wong & Tye, 2005). Another goal was to provide a hospital setting that does not gratify dependency needs (Ash & Galletly, 1997; Breslow, 1993). Also use of brief admission to facilitate ambulatory treatment through limitation of crisis hospitalizations and to lower rates of treatment disruption were clear goals (Berrino et al., 2011; Koekkoek et al., 2010). Reduction of repeated self-harm and suicidal crisis along with the prevention of death were obvious goals of Brief Admission (Ash & Galletly, 1997; Berrino et al., 2011; Morgan, 1993; Nehls, 1994).

Table 1. Overview of nine studies and methodological details

Author/Year	Level of evidence*	Research purpose	Design
Nehls (1994)	Level IV	Analyze psychiatric nurses' experiences with implementing an innovative psychiatric hospitalization program for persons with BPD	Qualitative study. Interpretive phenomenological approach. Hermeneutics (n=13).
Nehls (1994a)	Level IV	Describe the typical features of brief hospital treatment plans; understand the clients' lived experience of brief hospital treatment; and ascertain whether changes in hospital use occurred after participation in the program.	Qualitative study. Interpretive phenomenological approach. Hermeneutics (n=5)
Little & Stephens (1999)	Level VI	Demonstrate the clinical use of a patient-based voucher system for brief hospitalization	Case report
Koekkoek et al. (2010)	Level IV	How patients experienced the intervention and how it affected their relationships with mental health professionals and their daily lives.	Pre-posttest multi-method design with quantitative measures and qualitative interviews
Wong & Tye (2005)	Level IV	How the standard management protocol and special management contract relate to hospital admission.	Quantitative study. Retrospective review using naturalistic data from the Client Management Interface.
Ash & Galletly (1997)	Level IV	The role of a crisis unit within a comprehensive system of care.	Quantitative study. Prospective data collection. n=78 admitted patients
Morgan et al. (1993)	Level IV	Green Card Study, Evaluation of a treatment strategy to prevent nonfatal deliberate self-harm	Quantitative study. Retrospective design. n=212, randomization
Silk et al. (1994)	Level VI	A model for the short-term, time-limited inpatient treatment of patients with BPD within a general psychiatric inpatient unit	Practice report. Descriptive study.
Breslow et al. (1993)	Level IV	Effects of short-stay beds for brief admissions to a PES.	Quantitative study. Descriptive correlational study.
Berrino et al. (2011)	Level IV	Investigating the feasibility and outcome of crisis intervention programs for suicidal borderline patients.	Quantitative study. Prospective 3-month follow up.

Level I: Systematic reviews of randomized and non-randomized clinical trials, Level II: Single randomized and non-randomized clinical trials, Level III: Systematic review of correlational and observational studies, Level IV: Single correlational and observational studies,

Patients' diagnosis	Outcomes
Inpatient psychiatric nurses (n=5) and community mental health center clinicians (n=8), to obtain the perspective of both inpatient and outpatient providers.	Two themes emerged: controlling empowerment and mandating caring. The empowerment of brief hospital treatment plans is not mutual empowerment, but rather a form of power and control over one another. The paradox of mandated caring is that it is not freely given care, but it is care specified in advance, limited, and contextual.
Five clients diagnosed with borderline personality disorder and involved in the brief hospital treatment program for at least one year.	In times of crisis and prolonged distress, the brief hospital treatment plans meant that clients had access to a safe place. The danger of prolonged hospitalization was avoided. Clients used the hospital as a place to rest, when unusual life events became overwhelming. The hospital was used to fulfill normal, everyday needs for human contact and kindness. Through brief hospital treatment plans, people take shelter and inhabit hospitals but they do not dwell there. The hospital is a safe structure and provides — to a limited extent — the essence of home and community life, which is family, friends, some-where to go, and something meaningful to do.
31-year-old man, BPD, schizophrenia, polysubstance abuse, antisocial personality disorder	In contrast to four volatile admissions in the preceding 12 months, the patient had one uneventful 2-day admission in 13 months. Brief hospitalization provided psychological space for the patient and for the team.
n=11 patients. Of these, n=8 patients participate in the qualitative interviews. Patients had a DSM-IV diagnosis of BPD and a history of repeated or long-term admissions	Patients describe as core elements of the intervention: Time-out from daily hassles, reduced responsibility, contact with fellow sufferers, conversations with professionals, control over treatment.
n = 80 patients with BPD. 81.2 % was treated with a standard management protocol. 18.8% received a special management contract.	The special management contract group had significantly ($p<.001$) more psychiatric admissions but *not* more contacts with the emergency department.
40 men, 38 women. 17% diagnosed with BPD.	Most patients (77%) could be discharged directly into the community; 18% was readmitted during the follow-up period of 6 months.
BPD as diagnoses is not described. Experimental group n=101, Control group n=111.	Reduction in repetition of self-harm in the experimental group in comparison with the control group, no significant outcomes.
No data.	No data. Staff feel empowerment and willingness to engage with patients with BPD improved.
n=28. Patients were diagnosed with a personality disorder.	51 admissions were studied. They had a strong association with suicidality and substance abuse. 21 of 28 patients could be discharged after 3 days. The study was replicated after a year with another sample of 51 admissions, confirming the earlier results.
n=100 control; n=100 intervention Patients had a DSM-IV diagnosis of BPD	At 3-month follow-up, in the intervention group 8% repeated deliberate self-harm and 8% psychiatric hospitalization, vs 17% and 56% in the TAU group. The number of days in inpatient treatment and crisis intervention after discharge was significantly less in the comparison group. ($p<.05$)

Level V: Systematic review of descriptive , qualitative, and physiologic studies, Level VI: Single descriptive, qualitative, and physiologic studies, Level VII: Opinions from authorities, and expert committees. BPD: borderline personality disorder; PES: psychiatric emergency service; DSM-IV: diagnostic and statistical manual of mental disorders (4th edition); TAU: treatment as usual.

Table 2. Overview of Components of Brief Admission

Authors	Discussion of goals	Organization of a Brief Admission	Organization of a Brief Admission: Duration
Little & Stephens	Focus on management of immediate problems, facilitating rather than distancing community contact, medication, if indicated, and avoiding hospitalization.	Use of Brief Admission is discussed in advance with patient and clinician; also described in treatment plan.	Maximum of 3 nights.
Morgan	Reducing repetition of deliberate self-harm.	Use of Brief Admission is not discussed in advance with patient and clinician.	No mention
Wong & Tye	Proactive use of inpatient service aims to prevent unplanned and prolonged hospital stay which is potentially counter therapeutic.	Use of Brief Admission is discussed in advance with patient and clinician; also described in crisis plan	Maximum of 3 nights.
Ash & Galletly	Attending to issues of suicidality, aggression, and dangerousness; diagnostic assessment; rapid resolution of presenting crisis; linking patient to appropriate community resources to avoid dependency on hospital; relieving pressure on specialized inpatient services.	Use of Brief Admission is not discussed in advance with patient and clinician;	Maximum of 3 nights.
Silk et al.	Prevent early control struggles and fears of regression that patients with BPD frequently experience when they are admitted to and discharged from inpatient units. Goal is also a quick return to the community and to suggest better behavioral options for patient after discharge. Realistic small goals set for short admission.	Use of Brief Admission is not discussed in advance with patient and clinician.	7-14 days
Breslow	Develop alternatives for long-term hospitalization or gain diagnostic clarity, serving a respite function, providing a hospital setting that does not gratify dependency needs, and relieving pressure on inpatient beds	Use of Brief Admission is not discussed in advance with patient and clinician.	Maximum of 3 nights.
Koekkoek et al.	Facilitate ambulatory treatment through limitation of crisis hospitalizations and prevent power struggles between patient and professional over amount of care to be offered.	Use of Brief Admission is discussed in advance with patient and clinician; also described in treatment plan.	Maximum of 3 nights.
Nehls	Avoid conflicts about need for hospitalization. Avoid negative effects associated with frequent, prolonged hospitalization. Improve quality of life for clients. Prevent death.	Use of Brief Admission is discussed in advance with patient and clinician; also described in treatment plan.	2-5 days

Admission procedure	Interventions used during a Brief Admission	Conditions for premature discharge
The patient can request Brief Admission without intervention of clinician.	Reduction of medication. Fostering internal locus of control and involvement of patient in decision-making.	Discharge could follow self-harming behaviors, as written down in the treatment plan.
The patient can request Brief Admission without intervention of clinician.	No mention	No mention
The admission was scheduled for the patients	No mention	No mention
Patients presented acutely at hospital	The team was organized to provide a rapid response to the psychiatric, psychological, interpersonal, financial, and accommodation factors that had contributed to the need for admission. Firm limit-setting and use of treatment contracts.	Described in treatment contracts
Admission was planned or patients came via psychiatric emergency room	The patients attend a creative coping group daily, which is modeled after dialectical behavioral therapy. The group is designed specifically to help develop techniques to decrease suicidal/self-harmful behavior and to increase coping skills. All of the participants are expected to keep a daily journal to help them identify/organize/explore their feelings and behaviors	Discussed and written down in pre-admission contract.
Crisis hospitalization on the psychiatric emergency service.	Both individual and family crisis and problem-solving sessions. Psychotropic medication, if indicated. Consultation with outpatient treatment providers.	No mention
Admissions were planned in advance.	Patients' perspective: time-out from daily hassles; reduced responsibility; contact with fellow sufferers; conversations with professionals; control over treatment	Negotiated and written down in contract.
The patient can request Brief Admission without intervention of clinician.	Patients' perspective: safe place; someone to talk to	Discharge could follow self-harming behavior as written down in treatment plan.

2

Authors	Discussion of goals	Organization of a Brief Admission	Organization of a Brief Admission: Duration
Berrino et al.	No need for further inpatient treatment at crisis hospitalization discharge. Lower rates of treatment disruption, repeated self-harm, and suicidal crisis relapse at 3-month follow-up compared to treatment as usual. Fewer psychiatric hospitalizations at 3-month follow-up compared to treatment as usual.	Use of Brief Admission is not discussed in advance with patient and clinician.	5 days.

Another goal was to prevent power struggles between patient and professional about the amount of care to be offered and to avoid conflicts regarding the need for hospitalization (Koekkoek et al., 2010; Nehls, 1994; Silk et al., 1994). A quick return to the community and facilitating rather than distancing community contact were mentioned as goals of Brief Admission (Silk et al., 1994; Little & Stephens, 1999). Relieving pressure on specialized inpatient services was also mentioned as a goal (Breslow, 1993; Ash & Galletly, 1997).

Organization of a Brief Admission. Patients discussed and agreed upon the conditions for brief admission with the clinician in advance of times of crisis (Koekkoek et al., 2010; Little & Stephens, 1999; Morgan et al., 1993; Nehls, 1994, 1994a; Wong & Tye, 2005). Patient and clinician agreed on the frequency of brief admission, duration of brief admission, and use of brief admission in relation to their crisis plans. The duration of a Brief Admission ranged from a maximum of 3 nights in five studies (Ash & Galletly, 1997; Breslow et al., 1993; Koekkoek et al., 2010; Little & Stephens, 1999; Wong & Tye, 2005) to 5 nights in three studies (Berrino et al., 2011; Nehls, 1994, 1994a) to 14 days in another study (Silk et al., 1994). In all nine articles, the duration of the admission is reported to be clearly stated to the patient upon arrival at the hospital in order to prevent early control struggles and reduce the fears of regression that patients with BPD frequently experience when they are admitted to and discharged from inpatient units. Agreements regarding the use of brief admission are written down in a treatment or crisis plan.

Admission procedure	Interventions used during a Brief Admission	Conditions for premature discharge
Patients came via psychiatric emergency room	Provide active cognitive and affective support to integrate/ move away from present stress disorder. Facilitate therapeutic alliance Help express overwhelming experiences of rage, helplessness, and/or deception. Convey insight into repetitive patterns of idealized masochistic attachment. Focus on life events involving separation and loss yet on impaired mourning of significant affective relationships as a main target of the treatment. Interpersonal intervention with the family and other close friends, especially partners, to clarify communication processes and decrease acute conflicts. Teaching patient and family adapted coping behaviors. Psycho-education (illness, treatment and which problems are to be expected after discharge and how to respond to them. Provide active help in organizing acute treatment after hospital discharge.	No mention

The crisis plan is intended to remind the patient and clinicians of strategies that they find helpful when in crisis, and one of the recommended strategies may be the use of Brief Admission.

Admission procedure. In four of the studies reported on, admission to the hospital was initiated by the patient but in different ways depending on the study (Nehls, 1994, 1994a; Little & Stephens, 1999; Morgan et al., 1993). Some patients directly called the hospital to request a brief admission and thus without the intervention of a clinician. Responsibility for the use of a Brief Admission intervention was thus placed in the hands of the patient. Or, it is reported that decisions regarding brief admission were made in consultation with the patients' case manager or some other health care professional. The health care professional then arranges for the brief admission to the hospital when judged to be necessary in these cases. In the studies of Ash & Galletly (1997); Berrino et al., (2011); Silk et al., (1994) and Wong & Tye (2005) the patients were admitted after presenting at the Emergency Room or the admission was scheduled for the patients. In one other study, the patient was offered a series of admissions across a period of six months (Koekkoek et al., 2010); the frequency of the scheduled admissions depended on the previous inpatient service use by the patient.

Interventions used during a Brief Admission. The interventions used during the brief Admission differed greatly across the studies we examined. In 5 of the studies, the brief admission was solely a stay in the hospital, which offered only the possibility of the occasional conversation with a nurse (Little & Stephens, 1999; Morgan et al., 1993; Nehls, 1994, 1994a; Wong & Tye, 2005). Other studies describe an active, rapid

response to the psychiatric, psychological, interpersonal, financial, and/or housing factors contributing to the need for admission. Both individual and family sessions for crisis management and problem-solving were held for this purpose. In 2 of the 10 studies, medication was prescribed as necessary (Breslow et al., 1993; Little & Stephens, 1999). In the study by Koekkoek et al. (2010), it is mentioned that the prescription of medication should be part of ongoing ambulatory treatment.

Both Koekkoek et al. (2010) and Nehls (1994) describe the interventions used from a patient perspective. They used in-depth qualitative interviews with patients to describe patients' perceptions of conversations with nurses. Patients perceive the conversations with nurses on the ward and being given control over their treatment as being helpful.

For brief admissions of 3 or more days, the use of various therapeutic techniques, group activities, and both individual and family psychotherapy are described. In the Silk et al. (1994) study, patients attend a Creative Coping Group, which is modeled after Dialectical Behavioral Therapy (Linehan, 1993), on a daily basis. The group is specifically designed to help develop techniques to decrease suicidal/self-harmful behavior, increase coping skills, and put forth better behavioral options for the patient after discharge. All of the participants are expected to keep a daily journal to help them identify, explore, and organize their feelings and behaviors. Realistic small goals are also set for the brief admission.

Drawing on a psychodynamic crisis intervention program that was shown to be successful, Berrino et al. (2011) developed a set of interventions for a shorter five-day version of the program. The interventions were as follows:

- Provide active cognitive and affective support to integrate/move away from present stress disorder.
- Facilitate therapeutic alliance and develop a working alliance
- Help give expression to overwhelming experiences of rage, helplessness, or deception.
- Promote insight into repetitive patterns of idealized masochistic attachment.
- Address life events involving separation and loss with impaired mourning of significant affective relationships as main target of treatment.
- Interpersonal intervention with family, close friends, and especially partners to clarify communication processes and decrease acute conflicts.
- Teaching of coping behaviors to patient and family.
- Psycho-education with respect to illness, treatment, and problems to be expected following discharge and how to respond to them.
- Help with organization of acute ambulatory treatment following hospital discharge.

Conditions for premature discharge. The term "premature discharge" refers to a forced discharge due to violation of agreements on the ward for Brief Admission. In 4 of the 10 studies (Berrino et al., 2011; Breslow et al., 1993; Morgan et al., 1993; Wong & Tye, 2005), there was no mention of the conditions for premature discharge. In the other 5 studies, the conditions for premature discharge were discussed with the patient and made specific to the individual patient once agreement was reached on Brief Admission. The conditions for premature discharge were written down in the treatment plan or contract with the patient. Violation of the treatment contract could be a condition for premature discharge. In some other cases, discharge could follow self-harming behavior, aggressive behavior, or alcohol/drug use. In one of the studies, not showing up for a planned Brief Admission could be ground for immediate discontinuation of the Brief Admission (Koekkoek et al., 2010).

In the following, the research designs and study quality of the studies on the use of Brief Admissions with patients with BPD are reviewed.

Research designs

Morgan et al. (1993) used a Randomized Control Trail to study the effectiveness of their green card intervention on repeated self-harm. After a follow-up of one year they found a significant reduction of self-harm in the experimental group. Koekkoek et al. (2010) used a mixed method design with pre-posttest quantitative measures and qualitative interviews on how patients experienced Brief Admissions and how a Brief Admission affected their relationships with mental health professionals and their daily lives. In the studies of Wong & Tye (2005) and Breslow et al. (2005) retrospective information was gathered on how a standard management protocol and special management contract relate to hospital admission (Wong & Tye, 2005). And on the effects of using short-stay beds for brief admissions to a Psychiatric Emergency Service (PES) (Breslow et al., 1993).

Two quantitative studies gathered prospective information: One on the feasibility and outcomes of using crisis intervention programs with suicidal borderline patients (Berrino et al., 2011) and one on the incorporation of a crisis unit into a comprehensive care system (Ash & Galletly, 1997). The four qualitative studies have descriptive, phenomenological and case report designs. One descriptive qualitative study outlined a model for the short-term, time-limited inpatient treatment of patients with BPD within a general psychiatric inpatient unit (Silk et al., 1994). Two other qualitative studies were phenomenological (Nehls, 1994; Nehls, 1994a). One other qualitative study took the form of a case report (Little & Stephens, 1999). The experiences of patients and nurses with Brief Admissions were thus described in the qualitative studies.

Study quality

In general, the methodological quality of the nine studies included in our review was poor. The cross-sectional and pre-test/post-test studies had no control groups; the follow-up period was either brief; or follow up was lacking. Both the quantitative and qualitative studies also had small sample sizes (see Table 1). All of this should thus be kept in mind when interpreting the results of our review.

DISCUSSION

The main purpose of this review was to identify the evidence base for the use of a Brief Admission intervention with patients with a borderline personality disorder and to identify the key components of such an intervention. Although the number of articles was small and their methodological strength and quality was weak, it was nevertheless possible to define and describe some critical components of a Brief Admission intervention for patients with a BPD. Five core components of the Brief Admission interventions used with patients with BPD could be distinguished: 1) discussion of the goal of the Brief Admission with the patient in advance; 2) notation of the Brief Admission procedure in a written treatment or crisis plan; 3) clear understanding of admission procedure and duration of the Brief Admission; 4) description of the interventions used during the Brief Admission; and 5) specification of the conditions for premature discharge.

The ten studies show Brief Admission as an intervention to promote patient autonomy and empower the patient in the sense that the patient chooses a Brief Admission intervention to prevent a crisis or further crisis and often as part of a larger treatment plan. As far as we know, the components of a Brief Admission intervention have not been described to date despite Brief Admission frequently being used in the care for patients with borderline personality disorders worldwide.

Interventions offered during a brief admission

The extent of intervention offered during Brief Admission varied considerably across the studies we reviewed (as can be seen in Table 2, column 4). In some of the studies, patient's simply used the hospital as a safe place, as a respite, and as a place for ventilating conversations with nurses. In other studies, the patient was given an entire intervention program that included individual, group, and family sessions. The goal of the intervention program was to detect the source of the crisis, which was typically a relational problem and lack of coping strategies. During the group sessions, attention could then be focused on the development of coping skills and the building of the confidence needed to cope with emotions and thoughts. During the individual and family sessions, the focus could be on life events involving separation and loss with impaired mourning of significant affective relationships as the main target for treatment (Berrino et al., 2011). Alternatively, the building of support from family and

friends could be targeted in treatment along with the clarification of communication processes and the decrease of acute conflicts. Despite the Brief Admission being no longer than 5 to 7 days, Berrino et al. (2011) found a Brief Admission of 5 days with both individual and group sessions to be effective when compared to treatment as usual. There is no quantitative study of the outcomes of Brief Admission without individual or group sessions and a sufficiently large sample size, so the question of whether Brief Admission with individual, group, and family sessions produces better outcomes than Brief Admission without such sessions remains to be answered.

Conditions for premature discharge

Although the conditions for premature discharge are discussed with the patient and agreement is reached on forehand, it seems contradictory to discharge a patient with borderline personality disorder showing symptoms of being in crisis. Self-harm and thoughts of suicide are symptoms that indicate a crisis. Instead of actively teach patients to cope with these symptoms, patients are sometimes send home bare handed. This can be considered as missed opportunities for nurses and other disciplines to learn these patients' skills to cope with their symptoms.

Incorporation into stepped care

When Brief Admission is incorporated into a treatment plan or crisis management plan, it should become part of a stepped care treatment program. The patient should initially try — possibly with the help of family or a clinician — to reduce tension via talking to ventilate emotions, contact with a clinician or a crisis team, relaxing activities such as walking the dog, and so forth. When these actions do not help, the patient can turn to Brief Admission as a self-management tool and to prevent crisis.

Autonomy

It can be good for the growth of autonomy and self-management on the part of the patient to adopt a Brief Admission intervention. Particularly when the patient can be taken seriously, treated as an equal partner, and thus request the Brief Admission him/herself, the intervention is in line with the NICE clinical guideline (2009) for Borderline Personality Disorder, which recommends: the promotion of autonomy, choice, and active involvement of patients in the finding of solutions for their problems — also during crises.

Patients should be encouraged to consider various treatment options and the consequences of the choice(s) they make. The development of a crisis plan including self-management strategies that are likely to be effective and stipulation of how services can be accessed when self-management strategies alone do not appear to be enough is also recommended. And when Crawford et al. (2008) undertook a Delphi study of expert authors, service providers, and service users in the U.K., it was agreed

that the reduction of risk for people with personality disorders indeed entails giving them a high degree of choice and personal responsibility.

By applying the first three components of the intervention Brief Admission, like goal setting, negotiation about organizational aspect and the admission procedure, a focus on autonomy can be reached. This requires negotiating conversations with the patient, their ambulatory (community) clinician and the ward nurse of the clinic. In which a plan for the Brief Admission is made, with on the one hand organizational boundaries on frequency, duration and admission procedures. And on the other hand, a specific description on the attitude and interventions this patient needs being in crisis. Par example: some patients need structure, others space; some patients need an outreaching attitude of the nurses, other patients can be made responsible to get in contact with the ward nurses.

Strengths and weaknesses of the present study

In interpreting the present results, the methodological limitations on the studies we reviewed should be kept in mind. Literature was searched in all languages. It is nevertheless still possible that negative or non-significant outcomes with regard to Brief Admissions have not reached publication. Unfortunately, the results of the quantitative studies included in our review could not be compared to each other due to the heterogeneity of the research designs, study samples, outcome measures, and interventions. A meta-analysis was thus impossible, and the same held for the results of the qualitative studies.

Conclusion

Surprisingly, research regarding the effectiveness on the Brief Admission intervention for people with a borderline personality disorder is sparse. Five key components were identified from our review of the evidence-based literature: First, the goal of the Brief Admission is discussed with the patient prior to admission. Second, the organization of the Brief Admission and its duration is written in the treatment plan or crisis management plan. Third, the admission procedure is clearly understood by all those involved and particularly the patient. Fourth, any interventions undertaken during the Brief Admission are clearly described. And fifth, the conditions for so-called premature discharge are outlined and agreed upon. Despite a focus on autonomy, self-management, and empowerment of patients with BPD being recommended by the NICE clinical guideline (2009), research, both qualitative and quantitative, on the effects of Brief Admission on these variables has yet to be undertaken and should therefore be welcomed in the future.

Implications for nursing practice

There are indications that a Brief Admission intervention can effectively be put to use in the care for patients with borderline personality disorder. Self-harm and suicide can be prevented with a Brief Admission, and coping skills can also be promoted. A focus on empowerment and treatment autonomy is important in doing this for patients with BPD. To accomplish this an individual treatment plan for Brief Admissions should be made with the patient. The patient should be given the opportunity to organize a Brief Admission directly with the clinic, and be taken seriously, enhancing autonomy and empowerment.

Recommendations for further research

The results of this review provide a starting point for the building of an evidence base regarding Brief Admission as an intervention for patients with a borderline personality disorder. The results can help us identify the key components for Brief Admission and test the intervention as a whole. Complex mental health care interventions should be investigated and developed in an integrated process that includes formulation, feasibility assessment (i.e., pilot testing), evaluation, and implementation with a non-linear, dynamic interchange between the different stages throughout the development process (Craig et al., 2008). We suggest further qualitative research on the experiences of patients and clinicians with Brief Admission as an intervention. These research findings can be used to develop an intervention Brief Admission. Also the theoretic underpinnings explaining how this intervention should be provided to get the outcomes aimed for should be developed (Craig et al., 2008). Following with a thorough evaluation of the effectiveness of such intervention using an experimental design.

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Chapter 3

Experiences of patients with Borderline Personality Disorder with the brief admission intervention: A phenomenological study

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ABSTRACT

Brief admission is a crisis intervention for patients with borderline personality disorder (BPD), and refers to a clinical admission at a psychiatric hospital for a period of 1–5 nights. Patients formulate a treatment plan together with their community mental health nurse about the maximum frequency allowed for these brief admissions. The purpose of the study was to describe the lived experiences of patients with BPD with use of the brief admission intervention. The study used a phenomenological approach. Inclusion criteria were a diagnosis of BPD, according to the Diagnostic and Statistical Manual of Mental Disorders–IV criteria; experience with brief admission, and sufficient understanding of the Dutch language. A total of 16 female patients and one male patient participated in the study. Thematic analysis of the transcripts of the interviews revealed four major meaning units: (i) organization of the brief admission; (ii) contact with a nurse; (iii) time out from daily life; and (iv) experienced value for the patient. Patients highlighted the quality of the contact with a nurse as the most important aspect of the brief admission. Nurses should be aware of the importance of connecting with patients who have BPD during a brief admission, particularly in light of the interpersonal hypersensitivity that characterizes these patients.

INTRODUCTION

Borderline personality disorder (BPD) is characterized by interpersonal hypersensitivity, a fearful preoccupation with expected abandonment, and intense but unstable interpersonal relationships (Gunderson 2011). Other characteristics are affective instability, including intense anger, poor impulse control, and self-mutilating behavior (American Psychiatric Association 2000), but can also include disturbances and problems with self-direction (Bender & Skodol 2007).

Patients with BPD are known to experience lifelong struggles as a consequence of the deleterious effects associated with the disorder. They describe their experience of having a BPD diagnosis as living with a label and having self-destructive behavior, which is perceived by others as manipulation, and limited access to care (Nehls 1999). Holm and Severinsson (2011) revealed two themes in their study: struggling to assume responsibility for self and others and struggling to stay alive by enhancing self-development.

Patients with BPD are high-level users of health-care, social, psychiatric, ambulance, and emergency department services (Chiesa *et al*. 2002; Paris 2002). As well as this, they have been found to have significantly more impairments at work, in social relationships, and at leisure than patients with major depressive disorder (Gunderson *et al*. 2011; Newton-Howes *et al*. 2008; Skodol *et al*. 2002).

A community-based epidemiological study of 859 psychiatric outpatients in the USA found 9.3% to be diagnosed with BPD (Zimmerman *et al*. 2005). The median prevalence of BPD in the general Western population has been found to be 1.6% (Torgersen 2009).

Patients with BPD typically receive psychotherapy as outpatients, but they might also need pharmacotherapy, psychosocial support, and/or crisis intervention for suicidal thoughts or deliberate self-injury (Cleary *et al*. 2002). Treatment for patients with BPD is provided in different settings, including community mental health care, but also day care, brief admission, and/or long admission, with (psychotherapeutic) treatment as needed.

In the National Institute for Health and Clinical Excellence's guideline 78 (National Institute for Health and Clinical Excellence 2009) for the treatment of BPD, the development of autonomy and the promotion of choice are listed as key priorities for the implementation of treatment, with person-centered care as the recommended approach. The guideline states that patients should be actively involved in finding solutions for their problems, and should be encouraged and helped to consider different treatment options and life choices. This gives them an opportunity to learn and grow in autonomy. Empirical research, with regard to these recommendations, and the guideline as a whole, is nevertheless called for.

The unplanned hospitalization of patients with BPD in a general psychiatric setting has been found to have only limited value, and often negative consequences. Regression, repetitive admission, and non-recovery from long-term suicidal ideation

following discharge have been reported (Krawitz *et al*. 2004; Paris 2002). Acute admission is now predominantly held as the professional treatment goal.

According to the Dutch multidisciplinary guideline for the treatment of patients with personality disorders (Dutch Psychiatric Multidisciplinary Guideline Committee 2008), a 'brief admission' intervention can be helpful when patients with BPD are in crisis. According to this guideline, a brief admission has a maximum duration of 3 nights and requires a treatment plan that should be negotiated with the patient and a clinician prior to the first admission. The maximum frequency of brief admissions per year must be stipulated in each patient's treatment plan. This encourages patients to not only manage their brief admissions, but also make choices with regard to their treatment, treatment needs, and the use of brief admissions. Patient autonomy is thus promoted.

Empirical research on the use of brief admission as an intervention for psychiatric patients, and patients with BPD in particular, is largely lacking. A Cochrane review revealed a lack of sound quantitative studies on crisis interventions, including brief admissions, for patients with BPD (Borschman *et al*. 2012). Helleman *et al*. (2014) performed a narrative review and identified five core components of brief admission interventions used with patients with BPD: (i) discussion of the goal of the brief admission with the patient in advance; (ii) notation of the brief admission procedure in a written treatment or crisis plan; (iii) clear understanding of the admission procedure and duration of the brief admission; (iv) description of the interventions used during the brief admission; and (v) specification of the conditions for premature discharge. There are a few qualitative studies in which the experiences of patients with BPD using brief admission have been described (Koekkoek *et al*. 2010; Nehls 1994a,b). However, the sample sizes in these studies are small, (only 6 patients in the Nehls study and five patients in the Koekkoek *et al*. study). The methodologies are also not described in sufficient detail to judge their quality. Completely missing from the literature are studies describing the elements necessary for effective brief admission from the perspective of the patients themselves. The present study aimed to fill at least part of this gap, and to describe the experiences with brief admission for patients with BPD.

METHODS

Methodology

An interview study was conducted using the descriptive phenomenological methodology of Giorgi (2008). This methodology has been useful for uncovering and reducing the structure of a phenomenon to the critical elements using so-called 'bracketing', which requires investigators putting their understanding of a phenomenon aside (i.e. in brackets).

Participants

A total of 17 outpatients participated in the present study, which was conducted between January 2011 and August 2012. Inclusion criteria were: (i) a diagnosis of BPD according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders–IV (DSM-IV); (ii) experience with brief admission; (iii) Dutch speaking; and (iv) able to tolerate an interview. Patients with an inability to participate in the study, due to severe substance abuse problems, were excluded. The patients were all in care at a large mental health facility in a semi-urbanized, eastern part of the Netherlands.

Patients with experience in the use of brief admission were first sought to create a purposive sample. In order to do this, the patients were asked to participate in the study by their community clinician; neither age nor sex was taken into consideration. The clinician requested permission to pass the patient's contact information on to the investigator. A total of 27 patients were asked to participate, and 17 agreed. Reasons for declining were: (i) being in crisis; (ii) fear of the interview being recorded; (iii) intoxication; or (vi) no mention of a reason.

The mean age of the participants was 42.1 years (range: 28–59).

The mean frequency of brief admission used in a 3-year period prior to the interview was 12 (range: 2–68). The modus was three. These data were retrieved from the patients' medical record.

Description of the brief admission intervention

In the present study, the brief admission intervention was offered in four psychiatric clinics. The patients were admitted to an open ward.

Patients were admitted for 1–3 nights and could request contact with a nurse during that time. A brief admission treatment plan must be drawn up with the patient (i.e. prior to the first brief admission). Patients who request a brief admission are admitted when a bed is available. Upon arrival at the clinic, they are only seen by a nurse who discusses the specific goals of the patient's brief admission and other practical matters; they are not seen by a psychiatrist. Patients do not follow structured therapy groups during the brief admission (Fig. 1).

Data collection

A qualitative, in-depth interview was conducted with the 17 participants. The interviews had a duration of 45–75 min, were guided by an aide memoire, and based on clinical experience and a review of the relevant literature (Helleman *et al*. 2014). The aide memoire consisted of key words, which were used with the research question to guide the participants.

All of the interviews were conducted by the First author. The interview was initiated with the question: 'Could you tell me about your experiences with the brief admission

intervention?' The participants were then asked to describe their experiences in greater detail.

Data saturation was reached when no new meaning units were mentioned after the interviews were conducted with 15 participants.

Figure 1. Brief admission intervention

Preparing for a brief admission: Writing a treatment plan with the patient, clinic, and ambulatory clinician
Ambulatory clinician requests a brief admission arrangement for their patient at the psychiatric clinic in their city.
Patient, ambulatory clinician, and a nurse from the clinic make a brief admission treatment plan, which includes brief admission goal, allowed frequency (e.g. once a month), allowed duration (1-3 nights per brief admission), medication, preferred attitude from nurses, specification of the conditions for premature discharge, rules on alcohol/drugs use, and self-harm.
Notation of the brief admission procedure in a written treatment or crisis plan.
Goal of the brief admission
General goal of using brief admissions is to prevent self-harm or suicide, and help the patient regain control over him/herself. Other goals are to avert lengthy and costly admissions and dropouts of individual, and group therapy delivered in the community.
How is the brief admission organized in the Netherlands?
Brief admission is offered on psychiatric open wards throughout the Netherlands in almost every city.
Brief admission has been a common practice for more than a decade in the Netherlands.
Every ward or clinic has its own way of delivering the brief admission.
Brief admission is paid out of the medical insurance of the patients. Every patient in the Netherlands has medical insurance.
Ambulatory clinician is responsible for the long-term treatment plan.
Patient's request for a brief admission
Patient makes a call to their ambulatory clinician during office hours to request a brief admission.
Patient calls the clinic directly to request a brief admission outside of office hours.
Patient who requests a brief admission is admitted when a bed is available.
Upon arrival at the clinic, the patient is only seen by a nurse who discusses the specific goals of the patient's brief admission and other practical matters; they are not seen by a psychiatrist. Discharge date is also planned. After discharge, care and treatment is provided by the patients the ambulatory clinician.
During the brief admission
Patients do not follow structured therapy groups during the brief admission. Individual or group therapy programmes are offered in community care.
Patient can request a conversation with a nurse and an individualized brief admission treatment plan; individual actions and goals are discussed.
On most wards, the patient is responsible for their own medication.

Ethical considerations

All participants signed an informed, consent form. The study protocol was approved by the institutional review boards from the hospital and its university affiliate. The participants were recruited via a clinician. Participants' rights to anonymity, confidentiality, and withdrawal at any point during the study were explained in a letter, in a telephone conversation prior to the interview, and at the time of the interview.

Data analysis

The interviews with the participants were audio-recorded and transcribed verbatim. The meaning units in the transcripts were then identified and analyzed by four researchers to reveal current issues and patterns. Six steps were followed in the analyses, as described by Giorgi (1997; 2008; 2012).

1. Bracketing and phenomenological reduction. The researcher remained open to what the participants told her, and she did not engage her own understanding of the phenomenon.

2. Reading of the data to get a sense of the whole. The interviews were read and reread by the first and second researchers.

3. Division of the data into 'meaning units'. The texts were analyzed by the first and second researchers to discriminate 'meaning units' from a nursing and psychological perspective, with a focus on the phenomenon being researched.

4. Transformation of the data from the words of the participants to statements that reflected the psychological import of what had been said. Through a process of reflection and imaginative variation, the psychological aspects were elucidated in-depth in order to understand the events. This was done with all the four researchers.

5. On the basis of the transformed meaning units, the essential structure of the experience was outlined. A synthesis of the transformed meaning units into a consistent description of the psychological structure of the event was made.

6. Use of the essential structure to help clarify and interpret the raw data, with respect to the issue of interest. This is an internal validity check; the researchers went back over all the meaning units to ensure that all essential meaning units were included in the structure. After this, the findings were compared with existing literature.

MaQdata software (VERBI GmbH, Berlin, Germany) was used to manage the data. The meaning units identified are described and documented using comments from the participants.

RESULTS

Four meaning units emerged from the thematic analysis of the interviews: (i) the organization of the brief admission; (ii) the quality of the contact with a nurse; (iii) time out from daily life; and (iv) the experienced value of the intervention. These meaning units formed the essential structure of the experience.

Organization of the brief admission

Different aspects of the organization of the brief admission were discussed: the brief admission treatment plan, the specific goals of the brief admission, the admission procedure, and the conversation with the nurse at the start of the brief admission.

Brief admission treatment plan
In the interviews, the participants reported being very satisfied with the formulation of an individualized brief admission treatment plan, together with their community mental health clinician and a nurse from the clinic. It was also mentioned that it was important that the plan be regularly evaluated for its fit, based on the patient's needs. The needs of patients can vary from person to person, but also over time. Sometimes, a rest or time out is needed; and other times, rhythm, activity, or conversation of the ward is needed.

When the brief admission treatment plan is developed together with the patient, the following aspects are discussed: the frequency of the brief admission, the duration of the brief admission, and the specific goals of the brief admission for the individual patient. The aim of this discussion is to create agreement on the boundaries of the brief admission. The treatment plan further addresses such practical matters as whether or not the patient can call the ward directly to arrange for brief admission, or if the patient will be responsible for personal medication. The maximum frequency of a brief admission for each patient within a given period of time is also specified, along with how many nights the patient can stay:

> *Discuss with a patient what the expectations of the brief admission are .... Put this on paper, individually. What to expect from the clinic. Let this be clear. (Interview 6, line 173)*

Goals of the brief admission
The most important short-term goal reported for the brief admission was to overcome a crisis without loss of control. Patients tried to prevent negative outcomes, such as self-harm or suicide. Tension and emotions can be reduced with a brief admission. Another reported short-term goal was to reduce the chaos of busy thoughts, and thereby regain an overview of current emotions, thoughts, and problems. Patients reported needing a brief admission in order to be able to continue with intensive therapies, such as STEPPS (systems training for emotional predictability and problem solving) (Blum *et al*. 2008) or EMDR (eye movement desensitization and reprocessing) (Bisson *et al*. 2007):

> *The goal is, of course, to prevent worsening. ... To prevent ending up on a slippery slope. The brief admission can stop the slippery slope. (Interview 11, line 184)*

Admission procedure
The patients reported being able to call their community mental health-care clinician during working hours to discuss the use of a brief admission. They could also directly call the clinic to enquire about the possibility of a brief admission outside of working hours.

The patients further described how hard it was to call to prevent a crisis. Tensions can rise quickly, which makes it hard to make the call in time:

> *Sometimes I am much too late to ask for a brief admission. I am bad in setting limits or in recognizing when I am doing badly. (Interview 11, line 102)*

Conversation with the nurse at start of the brief admission

The patients described how a conversation at the start of each brief admission helped them overcome their fear of contacting a nurse. They reported that this conversation helped clarify practical matters, such as when to contact a nurse. They also reported discussing the goal of the brief admission and clarifying issues, such as what the patient was trying to achieve through a brief admission:

> *When I arrive, I have a conversation with the nurse. What do you need? What can I do for you? Who do you want to talk (about)? So that's all clear to me. (Interview 4, line 231)*

Contact with a nurse

The patients described contact with a nurse as the most important part of a brief admission. They described how difficult it was to open up during a crisis, and how contact with a nurse could help with this.

Overcoming a crisis

The patients described conversations with nurses as most helpful for overcoming a crisis, particularly when they felt the contact involved mutual trust. The patients felt that it was hard to start talking about problems and emotions when in the middle of a crisis, and reported feeling emotionally 'locked up', extremely tired, or confused, which made it harder to share their thoughts and emotions. Thus, they needed the nurse to play an active role and ask the patients about problems at home, current thoughts, and feelings. The patients also mentioned how the nurse could help structure conversations.

Getting the patient to talk about problems, thoughts, and emotions was reported to help reduce the patient's level of tension and emotion:

> *The nurses think about things which I cannot think about at such moments. What I can do to find distraction, for example (and) how to handle things the next time. You learn what causes the problems, why you react the way you did. I think about these conversations, even after discharge. (Interview 6, line 111)*

The patients reported feeling safe when they were welcome, seen, and heard. This was viewed as being important for organizing the chaos in their heads and heart, or when negative thoughts and feelings predominated. Contact with others can give rise to fears of rejection, disapproval, or conflict, which make it hard for patients to take initiative and enter into a conversation with a nurse. It can help if they know which nurse they can talk to, and it is easier to approach the nurse if the nurse makes the conversation informal, such as over a cup of coffee or on a walk with them.

Meaning of the contact/conversation with a nurse for the patient

Contact with a nurse enabled patients to reconnect with themselves. During this contact, they felt seen, heard, and accepted, and safe enough to make share their vulnerabilities with the nurse:

> *If they connect with you and ask you what went wrong or what they can do for you; that is so nice. The nurse talked with me for 30 min; it was a revelation. It removes a rock from my heart. I melted and felt heard, and I told her stuff. (Interview 17, line 159)*

> *Talking can help make things clear. That reassures me. It prevents me from becoming really depressed, or automutilate or attempt suicide. (Interview 4, line 129)*

When there is no contact with a nurse

The patients sometimes felt that they could not approach a nurse or that the brief admission did not allow for conversations with nurses. Without such contact, feelings of tension, abandonment, rejection, loss, and anger were reported to worsen. There was no relief of tension or emotions, and the brief admission was viewed as not having a positive effect. In these cases, an opportunity to help the patient reflect on the situation was also clearly missed. Disruptive behaviors, including verbal aggression, auto-mutilation, or alcohol and drug use could sometimes occur as a result:

> *It can be very frustrating. I felt so alone. I thought the staff would check on me, but they left me all alone. The panic didn't become less. I didn't get any structure, support, or feedback. (Interview 9, line 44)*

> *Once, the tension went running so high that I flipped. I had to go to the closed ward then. (Interview 7, line 97)*

Time out from daily life

Most of the patients highly valued being able to take a step back from daily life during a brief admission to get some rest, distraction, and structure, and meet fellow patients.

Rest

Getting a lot of sleep and rest is perceived as helpful to recovery. Getting away from the busy responsibilities of daily life for a short period and having less disturbance were found to help patients relax:

> *You feel safe when you're in the clinic. At home, I go on and on, and I run around like a chicken with its head cut off. In the clinic, I surrender, feel my tiredness, and (I) rest. (Interview 9, line 102)*

Distraction

Pleasant, distractive activities help decrease the level of tension. Having a cup of coffee with other patients or the nurse, taking a walk, taking a bath, having a cigarette, participating in ward activities were reported to provide relief. Nurses can assist by identifying potential, pleasant activities.

Structure

The structure of a ward with its planned coffee breaks and meal times can help patients regain control of their lives. Many patients have overwhelming thoughts and feelings prior to admission due to no structure in the home. Daily conversations with a nurse to plan the day and achieve a balance between activity and relaxation can provide much-needed structure. On some wards, patients can participate in ward activities, such as sports events and group sessions, which is highly valued by patients:

> *To find the structure again. Like ... the sleeping times, the meal times. (Interview 4, line 153)*

Fellow patients

Contact with fellow patients is also reported to provide support. Patients sometimes know each other from earlier admissions, and therefore, understand each other's problems, but it can also be difficult to maintain clear and healthy boundaries when in contact with other patients. Such contacts run the risk of taking care of others, rather than oneself, and contact with a disturbed or confused patient can be experienced as being unsafe:

We understand each other. Even if we have a different sickness, we understand. (Interview 5, line 92)

In the beginning, I went helping others, you know, but then I stopped. Now I say, just go to the nurse, that's what they're here for. I am here for my own problems. (Interview 2, line 84)

Experienced value for the patient

The results of a brief admission can be either positive or negative. Relaxation and prevention of a total loss of control are perceived as positive aspects. Patients can get the relaxation that they cannot get at home with a brief admission. Their energy levels rise as a result, and they regain the strength needed to function in daily life at home, with their families, and at work:

Can't say the whole crisis was over, but I came home more relaxed and was able to work again. (Interview 7, line 111)

As they became more experienced with brief admissions patients reported becoming more autonomous and taking greater responsibility for their recovery. They also reported improved self-esteem when the brief admission experience worked for them. The availability of a brief admission in times of crisis, also gave patients a sense of security. Knowing that they could request a brief admission when they needed one was reassuring. Feelings of being unseen or unheard and loneliness were perceived as negative aspects of a brief admission. The location of the patient's room in some psychiatric hospitals and the organization of the brief admission could also contribute to this. The rooms of patients with a brief admission are sometimes located quite a distance from the main ward in hospitals. This can give rise to feelings of isolation, abandonment, and even rejection, especially because patients with BPD are already predisposed to think along these lines. Brief admissions, particularly in combination with increased tension, can thus increase, rather than decrease, feelings of loneliness:

I felt so alone there. I expected someone to check up on me, but no one came; they just left me there. (Interview 9, line 44).

DISCUSSION

The findings of this study revealed four meaning units from the perspective of the patients: (i) organization of the brief admission; (ii) contact with a nurse; (iii) time out from daily life; and (iv) experienced value for the patient.

Our results showed that patients valued the time-out aspect of brief admissions, but also the opportunity to interact with other patients. This is supported by Bowen's

(2013) findings, in which patients viewed peer support as a vital component of their growth. Further, it showed that patients sometimes experience difficulties in their contact with other patients, and problems with maintaining healthy limits, in particular.

Koekkoek *et al*. (2010) found that the process of jointly developing the individual brief admission treatment plan with the patient, thus assuring agreement with the plan, was important for successful intervention. Similarly, in our study, the patients valued in-depth discussion and development of the brief admission treatment plan, together with their clinician from an outpatient clinic and a nurse from the clinic for brief admissions. Part of this discussion involved explicit identification of the benefits of brief admission for the patient, but also specification of the maximum frequency, duration, and goals of the brief admission, and questions what each patient needs to recover from a crisis or avoid a crisis; for example, distraction, contact, or respite.

In the present study, the patients described their contact with nurses, and the features and obstacles which characterize this. They described the contact with a nurse as the most important aspect of brief admission. Such contact can help them overcome a crisis, and could simply take the form of talking, distraction, company (i.e. not being alone), or feeling cared about and taken care of. This is in line with the described common factors from treatments of BPD, in which attention to affect and an active approach from the clinician are named (Weinberg *et al*. 2011). The patients also mentioned difficulties in their contact with nurses, such as feelings of being ignored, misunderstood, or being met with anger.

Gunderson and Links's (2014) model of the manifestation of BPD can shed some light on the occurrence of brief admission difficulties, and particularly in patients' contact with nurses and other patients. Gunderson and Links (2014) drew upon research outcomes, expert opinions, and practice experience to characterize the possible inner processes of patients when interacting with others, including nurses, spouses, and other family members. These can range from feeling 'connected' (i.e. a high level of functioning), to feeling 'threatened' or 'alone' and to feelings of 'despair' (i.e. a low level of functioning). The model shows that a 'holding' and 'supporting' attitude from the nurse can help patients recover. Most crisis situations arise from problems in relation with others in the home. Rejection or perceived rejection can make a patient with BPD feel threatened, and thus give rise to feelings of anger, anxiety, and self-devaluation, but also self-harm or help seeking. Patients with BPD need to feel connected to recover from a crisis (Gunderson & Links 2014).

Based on our findings, communication and support from a nurse can help a patient recover. In contrast, being ignored or met with anger can only make the patient feel more vulnerable, more disconnected, and more alone, with symptoms of dissociation, paranoid thoughts, and/or rejection of any further help or attempts at contact as a result. Tension increases, and the current crisis remains unresolved. So what does a

holding and supporting attitude involve? Patients need to feel that they are seen, heard, accepted, and supported. This might take the form of rest, distraction, conversation, companionship, or in-depth discussion of a crisis, depending on the patient and the situation. It can help patients if they are asked about what they would think/feel, how they would attempt to cope, and who they would turn to if they could not manage their feelings (Siefert 2012).

Patients described a growth in autonomy and self-esteem, a feeling of security, and growing sense of responsibility for their own recovery when using brief admission. Fallon (2003) described the journey of patients through the systems of care as a travel that can be seen as an ongoing process of movement between settings of care and levels of independence. The overall goal of treatment of brief admission for the patient is growth in coping with the symptoms of BPD and in autonomy. Nevertheless, patients will experience crises during their treatment. A brief admission can prevent a total loss of control. Patients regain the strength needed to take responsibility to function in daily life.

Implications for practice

The brief admission intervention can only work if there is a collaboration of the psychiatric clinics with the mental health community care. As stated by Fanaian *et al.* (2013), an integrative and collaborative whole-service approach in the community is important, and in practice, is often lacking. In some areas, a culture shift in thinking and a reorganization of resources is necessary to be able to organize brief admissions. Lamont and Brunero (2009) found that the assessment, treatment, and ongoing management of people with personality disorders need to be embedded within mental health services.

Nelson (2013) stated that a unified team-based approach is necessary to provide a brief admission for patients with a BPD, together with improved coordination with the outpatient provider.

Discussion of study strengths and limitations

It cannot be claimed that the experiences of brief admissions described by one small group of patients with BPD represent the views of brief admissions for every patient with BPD. The participants in our study all lived in the Netherlands, which means that the context of Dutch mental health care influenced our findings. Nonetheless, the present findings can contribute to the international knowledge base, because all of the patients were diagnosed using internationally recognized DSM-IV criteria. A particular strength of the present study was the use of a sufficient number of participants to attain data saturation.

CONCLUSIONS

Four key elements emerged from the descriptions of the brief admission experiences of patients with BPD in the present study: (i) organization of the brief admission; (ii) contact with a nurse; (iii) time out from daily life; and (iv) experienced value for the patient. Our patients reported the quality of the contact with a nurse to be most important. Nurses should thus be aware of the significance and value of connecting with patients with BPD in light of the interpersonal hypersensitivity of such patients. In order to improve nursing care for patients with BPD, and the use of brief admission in particular, we recommend the following:

(i) brief admission in cases of BPD requires a thorough understanding of the disorder, its features, and its dynamics; (ii) knowledge of possible transference reactions, provoked by the patient, is important for connecting with patients. This implies that the clinic must have a vision with regards to the treatment of patients with BPD during brief admission; (iii) a multidisciplinary team should develop a policy on the provision of brief admission for patients with BPD, and should offer courses on the dynamics of BPD; and (iv) the formulation of an individualized brief admission treatment plan with the patient, the clinician from the outpatient clinic, and a nurse from the clinic is highly recommended in order to establish agreement on the goals, frequency, and duration of the brief admission, and the patient's need for contact.

Based on this, it is recommended that patients be questioned on actions or activities which have helped alleviate tension for them in the past.

An active role for the nurse during brief admissions is also advisable. If the patient does not approach the nurse for a conversation, then the nurse should approach the patient. Keeping the focus on here-and-now situations and the feelings of patients might also help the patient refocus and recover from a crisis or pending crisis.

Finally, supportive reactions from nurses are perceived to be calming. If a nurse acknowledges a patient's struggles, then the patient feels accepted as a person. Achieving this requires connection with the patient, and such connection and acceptance can heal.

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Chapter 4

Brief admissions during prolonged treatment in a case involving Borderline Personality Disorder and posttraumatic stress disorder: Use and functions

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ABSTRACT

Background: This study describes the use of brief admissions to a psychiatric ward by a single patient across a period of 7 years. The patient suffered from a borderline personality disorder and a complex posttraumatic stress disorder.

Objective: The purpose of this study was to describe how brief admission may be used during a longterm treatment process.

Design: A single-case descriptive study with triangulation of the data was undertaken. Semistructured interviews were conducted with the patient and the patient's spouse, psychiatrist, ward nurse, and community psychiatric nurse. Other data were retrieved from the medical records of the patient.

Results: Four phases could be distinguished in the treatment of the patient: crisis, treatment of posttraumatic stress disorder, treatment of borderline personality disorder, and recovery. The use of brief admissions positively influenced the course of treatment.

Conclusions: Brief admissions were initially used to prevent self-harm and suicide. The goals and functions expanded to prevention of prolonged admission, prevention of dropout from evidence-based therapy, and practicing with newly acquired skills and promotion of autonomy.

INTRODUCTION

Borderline personality disorder (BPD) is characterized by an interpersonal hypersensitivity, marked by a fearful preoccupation with expected abandonment and usually intense, unstable interpersonal relationships (Gunderson, 2011). Other criteria are affective instability, including intense anger, poor impulse control, nonsuicidal selfinjury (NSSI) behavior (*DSM-IV*; American Psychiatric Association, 2000), and disturbances of identity and selfdirection (Bender & Skodol, 2007). In the Netherlands, the lifetime prevalence of posttraumatic stress disorder (PTSD) has been reported to be 7.4%. Women and younger persons show higher risk of PTSD (de Vries & Olff, 2009). The U.S. National Comorbidity Survey Replication estimated the lifetime prevalence of PTSD among adult Americans to be 6.8% (Kessler et al., 2005).

Patients with BPD suffer greatly from the disorder and its consequences in their daily lives. Patients with such a disorder tend to be high-level users of health care, social resources, and particularly psychiatric inpatient services, outpatient care services, and emergency care services (Chiesa, Fonagy, Holmes, Drahorad, & Harrison-Hall, 2002; Paris, 2002). Patients with BPD are also found to have significantly more impairment at work, in social relationships, and even in their leisure time when compared with patients with major depressive disorder (Gunderson et al., 2011; Newton-Howes, Tyrer, & Weaver, 2008; Skodol et al., 2002).

Prevalence of BPD in treatment populations is found to be 10% in psychiatric patients in community care and 20% in psychiatric patients admitted to psychiatric hospitals (Paris, 2010).

A “brief admission” intervention is not a standard element of current internationally accepted treatment but can potentially be helpful when patients with BPD are in crisis (Berrino et al., 2011). However, brief admission as a mental health intervention has not been internationally well defined. According to a Dutch guideline, a brief admission has a maximum duration of 3 nights and requires a treatment plan negotiated with the patient and a clinician *prior* to the first admission (Dutch Psychiatric Multidisciplinary Guideline Committee, 2008). The maximum *frequency* of brief admissions per year must be stipulated as part of each patient’s treatment plan. And the negotiation of the treatment plan is aimed at encouraging patients to not only manage their brief admissions but also adequately identify their treatment needs, make well-informed choices for treatment, and thus use brief admission in a clear and productive manner. The underlying assumption is that patient autonomy can be promoted using brief admission as an intervention (Helleman, Goossens, Kaasenbrood, & van Achterberg, 2014b).

Empirical research on the use of brief admission as an intervention for psychiatric patients and, in particular, patients with BPD is lacking. The absence of sound quantitative studies on crisis interventions, including brief admissions, for patients with BPD was reported in 2012 (Borschman, Henderson, Hogg, Phillips, & Moran, 2012). In a

narrative review of 10 articles concerned with brief admissions, however, Helleman, Goossens, Kaasenbrood, and van Achterberg (2014a) were able to identify five core components of brief admissions when explicitly used as an intervention for patients with BPD: (a) discussion of the goal of the brief admission with the patient in advance, (b) notation of the brief admission procedure in a written treatment or crisis plan, (c) clear understanding of the admission procedure and duration of the brief admission, (d) description of the interventions to be used during the brief admission, and (e) specification of the conditions for premature discharge. Completely missing from the literature are studies of how brief admission may be used during a long-term treatment process. The present study thus is a first attempt that aimed to fill this gap by describing the experiences with brief admissions for a patient suffering from severe symptoms of the BPD and a complex PTSD, during a period of 7 years.

METHOD

A descriptive qualitative case study design was adopted to explore a case over time, within its real-world context through detailed, in-depth data collection.

Multiple sources of information were relied on to triangulate the data and reach convergence on the functions and use of brief admissions across an extended treatment period (Yin, 2014). The sources of information were the patient herself, her husband, the patient file, her psychiatrist, her community psychiatric nurse, and a clinical nurse involved in her care. The methods of data collection were individual interviews and chart reviews. We selected the particular case reported on here because of the presence of a diagnosis of BPD and the patient’s frequent use of the brief admission intervention across an extended period of time.

Semistructured interviews were conducted. The interviews were audio-recorded and transcribed verbatim for subsequent coding. Data from the patient’s medical records were also collected to confirm the information provided in the interviews.

An interview topic list was developed on the basis of the authors’ clinical experiences and reading of the relevant research literature. The focus of the interviews was on reconstructing the patient’s treatment history and the use of brief admissions in particular. Of particular interest was the use of brief admissions by the patient during the different phases of treatment.

Key concepts in the transcripts were identified, coded, and analyzed by two researchers to reveal the core functions and patterns of brief admission use with the use of MaQdata software (VERBI GmbH, Berlin, Germany); the intermediate analyses were then discussed within the research group.

The study protocol was approved by the institutional review boards of the hospital and its university affiliate. The rights of all respondents to anonymity and confidentiality and to withdraw from the study at any point were explained in a telephone conversation prior to the interview and again at the time when the interview

was conducted. All respondents signed an informed consent form and read and approved the final report. The results were anonymized.

RESULTS

The case is of a 37-year-old female who was referred to our psychiatric clinic by her general practitioner in 2008 for symptoms of severe self-harm and suicidal thoughts. She was then diagnosed with BPD and PTSD. She was interviewed twice, and for the duration of an hour on both occasions. Her husband, psychiatrist, community mental health nurse, and in-hospital nurse were interviewed once, and for approximately 1 hour. The purpose of these interviews was to get information about the treatment history and the use of brief admissions from different sources and different perspectives. The biography of Mrs. Peters (pseudonym) will first be considered and then her use of brief admissions and their function during the four phases of her treatment.

Biography

Mrs. Peters was born with spina bifida and has been confined to a wheelchair. This was very difficult for her because she was hampered in activities due to her inability to walk. Her mother did not adapt the home for her wheelchair, which made daily life even more difficult. Looking back on her childhood, Mrs. Peters felt neglected by her mother. Mrs. Peters has an older sister. She has no contact with her biological father. Up until the age of 9 years, her mother lived with a man who Mrs. Peters considered a father figure. After this relationship ended, her mother had several other relationships and lived together with a man on various occasions.

At the age of 11 years and after severe bullying at her primary school, Mrs. Peters was sent to a boarding school for handicapped children. Mrs. Peters dreaded going home for the weekend because her mother had not adapted her home for wheelchair use. This made Mrs. Peters feel not only unwelcome but also unseen. Mrs. Peters stayed at the boarding school where she was repeatedly sexually abused by a staff member until the age of 17 years. The sexual abuse resulted in pregnancies and miscarriages, which Mrs. Peters did not mention to anyone at the time. When Mrs. Peters informed her mother of this years later, her mother did not respond in a supportive manner, which caused considerable emotional pain for Mrs. Peters. The abuse was never reported to the police.

After boarding school, Mrs. Peters lived in a sheltered community for handicapped adolescents. Thereafter, she lived in an apartment on her own and met her current husband, until she decided to live together with him. It was difficult for her to trust a man and to engage herself fully in this relationship. According to her husband, Mrs. Peters had problems getting attached to him, physically and emotionally, and to share

her emotions and thoughts with him. Her husband confirmed it was sometimes hard for him, but he was able to adapt.

Mrs. Peters completed a training program for administrative work and an additional vocational course for the organization of daily activities in retirement homes. She has never had a paid job, but was working as a volunteer at a retirement home.

Mrs. Peters has a couple loyal friends who she has known for more than 15 years. She nevertheless has difficulties with closeness and distance in her contacts. She may pay daily visits to friends, for example, which is not always appreciated.

Mrs. Peters has been married to her husband for 10 years and had a relationship with him for over 18 years. At the start of their relationship, it took her a long time to open up to him and to trust him.

Mrs. Peters describes herself as a cheerful and social person. She likes creative activities, chatting on the computer, and music. Now and then she can still be distrustful in contact with others. Over the years, Mrs. Peters has managed to cope with her trauma symptoms such as nightmares and dissociation.

Mrs. Peters had a severe and acute onset of PTSD and the symptoms of BPD. The crisis was triggered at the sight of a deceased baby while paying a mourning visit to her family. This incident evoked non-suicidal self-injury (NSSI). Mrs. Peters was referred to the crisis service of the mental health facility by the general practitioner on account of destructive behavior, which gave reasons for concern: She was driving around town in her wheelchair at night while harming herself. Her treatment started in 2008.

Four Phases in the Long-Term Treatment of Mrs. Peters

Four phases could be distinguished in the treatment of Mrs. Peters. Phase 1, the crisis in 2008; Phase 2, the treatment for PTSD during 2009 to 2010; Phase 3, the treatment for BPD during 2011 to 2013; and Phase 4, recovery in 2014. Brief admission (BA) as a mental health intervention was introduced during Phase 2 of her treatment. The relevant diagnoses, medications prescribed, accompanying interventions, and use of BA as an intervention are summarized for the subsequent phases of treatment below.

The Use and Functions of Brief Admissions During Treatment Phase 1

During Phase 1, or the crisis phase of treatment in 2008, the goal of treatment was to minimize NSSI, emotional turmoil, and suicidal thoughts. This was done by offering the structure and protection of long-term inpatient admissions and pharmacotherapy. A combination of trazodone, topiramaat, and fluoxetine (Table 1) was prescribed by the clinic’s psychiatrist at the start of treatment to ease the depressive symptoms and emotional turmoil that Mrs. Peters was experiencing. The reason for the inpatient admission was very severe NSSI combined with emotion regulation problems, self-hatred, and lack of self-agency. The goals of the inpatient admission were to teach her to ask for help in a healthy way, to reduce stress, and to reduce the NSSI.

Table 1. Overview of pharmacotherapy

2009	Trazodon	100 mg 1dd1/2
	Topiramaat	100 mg 2dd1
	Fluoxetine	20 mg 1dd3
2010	Trazodon	100 mg 1dd1/2
	Topiramaat	100 mg 2dd1
	Fluoxetine	20 mg 1dd3
	Clonidine	0.025 mg 1dd4
	Lorazepam	2.5 mg 1dd1
	Haloperidol	1 mg 1dd1
		If needed 1dd1extra
2011	Trazodon	100 mg 1dd1/2
	Topiramaat	100 mg 2dd1
	Fluoxetine	20 mg 1dd3
	Clonidine	0.025 mg 1dd4
	Lorazepam	2.5 mg 1dd1
	Haloperidol	1 mg 1dd1, if needed 1dd1 extra
	Quetiapine	25 mg 1dd1 from 9-2011
2012	Trazodon	100 mg 1dd1/2
	Fluoxetine	20 mg 1dd3
	Clonidine	0.025 mg 1dd4
	Lorazepam	2.5 mg 1dd1
	Haloperidol	1 mg 1dd1 if needed 1dd1 extra. Stop 02-2012
	Haloperidol	1mg 1dd1 from 03-2012
	Quetiapine	25 mg 1dd1 through 07-2012
	Topiramaat	100 mg 2dd1 from 01-2012
2013	Trazodon	100 mg 1dd1/2
	Lorazepam	2.5 mg 1dd1 stop 01-2013
	Lorazepam	1 mg 1dd2 start 03-2013
	Fluoxetine	20 mg 1dd3 stop 05-2013
	Fluoxetine	20 mg 1dd2 start 02-2013
	Clonidine	0.025 mg 1dd4 stop 05-2013
	Haloperidol	1 mg 1dd1 stop 01-2013
	Haloperidol	1 mg 1dd2 start 03-2013
	Topiramaat	100 mg 2dd1
2014	Trazodon	100 mg 1dd1/2
	Haloperidol	1 mg 1dd2
	Topiramaat	100 mg 2dd1
	Lorazepam	1 mg 1dd2
	Fluoxetine	20 mg 1dd2

From the onset of the admission, the risk of hospitalization and regression was high because of the dependent behavior of Mrs. Peters. To prevent ambivalent reactions (NSSI) by Mrs. Peters, in relation to her perceived threat of her autonomy, the goals of admission were evaluated with her on a weekly basis. The nurses offered support, but the responsibility for her safety remained with Mrs. Peters, while the psychiatrist discussed her dependent and regressive behavior with her. The principles of Dawson and MacMillan, relationship management of the borderline patient, were followed during this admission (Dawson, 1988). During the course of her stay on this nonspecialized psychiatric ward, it became clear that long-term admission confirmed Mrs. Peters’ feelings of powerlessness and insecurity. She let go of responsibility for her

own recovery. It also became clear that the NSSI were still present. It was thus decided by the mental health care professionals at the clinic that the goals of treatment could not be met via long-term admission. This decision gave rise to a struggle between the patient and psychiatrist over the need for and purpose of long-term psychiatric admission. The message to the patient was that she, alone, is responsible for the NSSI and that she, alone, must work on minimizing the NSSI even though she considered herself incapable of doing this. Outpatient treatment started.

On several occasions following her discharge from the psychiatric clinic, Mrs. Peters requested long-term inpatient admissions. On each occasion, she was not re-admitted because, according to the psychiatrist, this would only confirm her feelings of helplessness. To solve this impasse, she was referred for a 4 days a week structured day-treatment. Mrs. Peters explained that BA as a mental health intervention was not initiated during this phase of her treatment because she was unable to ask for help, had very negative thoughts, and lacked self-esteem.

The Use and Functions of Brief Admissions During Treatment Phase 2

In the second phase of the treatment of Mrs. Peters at the start of the period 2009 to 2010, the symptoms of trauma became more prevalent and the psychiatrist changed the diagnosis from an adjustment disorder to PTSD (Table 3). Individual psychotherapeutic treatment for PTSD in combination with a 4-day structured group program was initiated to provide the support needed. According to Mrs. Peters, she could not use BA as an intervention in 2009 because she was still unable to ask for help.

In 2010, specific EMDR treatment for complex PTSD, known as EMDR-2 (eye movement desensitization and reprocessing; Bisson et al., 2007) was provided in combination with the support of a community psychiatric nurse, pharmacotherapy, and initiation of the use of BA as a mental health intervention. Haloperidol, clonidine, and lorazepam were added to the prescribed medication (Table 1) to ease the symptoms of anxiety, sleeping disorder, hallucinations, and PTSD. Mrs. Peters suffered from self-critical hallucinations due to high stress levels caused by the onset of PTSD symptoms, like intrusions and nightmares. These hallucinations occurred without her losing reality, as described as symptoms of BPD in the *DSM-IV*. Clonidine was prescribed to reduce stress and nightmares.

After the start of the EMDR-2, a 15-day inpatient admission was required to deal with the aggravated symptoms from PTSD and BPD: Mrs. Peters reported hearing voices that told her to cut herself and she could not sleep. These voices where activated as a result of a high stress level due to the reenactment of feelings and memory of her trauma. Feelings of panic evoked selfcritical hallucinations without loss of reality. Mrs. Peters was offered support during the inpatient admission to reduce her fear of abandonment and to help her cope with her feelings of panic. The clinical admission was offered with a clear and single goal within a time frame of 15 days, namely,

offering support to learn to cope with emotions. It resulted in a decline of stress and PTSD and BPD symptoms.

After completion of the EMDR-2 treatment and according to Mrs. Peter's husband, she gained control over her PTSD symptoms and the symptoms of dissociation; the incidence of NSSI also declined. Mrs. Peters was now more able to reflect on her thoughts and feelings. A community psychiatric nurse started supporting Mrs. Peters, but reported that Mrs. Peters did not dare to come into contact with the nurse at that time, had an offensive attitude, and did not speak her mind. She was not only distrustful but also fearful of being abandoned by the community psychiatric nurse at the same time. Establishing trust in the therapeutic relationship was the first aim. The second aim was to build up the daily activities and social contacts of Mrs. Peters. To help achieve this aim, Mrs. Peters started going to a Daily Activity Centre for psychiatric patients.

Start of Brief Admissions Usage. The psychiatrist we interviewed explained that the rationale behind the addition of BA to the treatment of Mrs. Peters was to enhance autonomy and prevent regression. BA worked on different levels. The message to Mrs. Peters was that only she can save herself; no one else can do that for her. By working to save herself, she could also strengthen her skills and autonomy. And she could thus take the lead in her own recovery process. With the introduction of BA as an intervention, it was made clear to Mrs. Peters that the decision to ask for help and then make use of a BA lies with her. She could contact clinicians to discuss her need for a BA and just how long this should be. The psychiatrist also mentioned that BA had a symbolic value. Rather than cry out for help, Mrs. Peters needed to initiate discussion of her trigger for the current crisis, what had upset her, and what she needed to calm down.

Before the start of using BA as an intervention in 2010, a plan for its use was formulated with Mrs. Peters, the community psychiatric nurse, and the ward nurse. Mrs. Peters could call the clinic 24 hours a day, to request a BA. The BAs started with a discussion with the ward nurse to make agreements on the daily contact with the nurses during the BA. The goal of using BAs at this time was to prevent NSSI, suicide, and the need for longer admission. An additional goal of using BAs was to prevent dropout from ongoing treatment. Initially, the frequency for a BA was set at no more than once a week. During the EMDR-2 treatment, however, an exception was made and Mrs. Peters could be admitted up to three times a week (for a maximum of one night per occasion). Later in the year, when Mrs. Peters lost a beloved family member, psychotic symptoms occurred. She reported hearing a voice that told her to set fire to herself, which she claimed was prevented by using BAs. An exception was again made to the maximum of one BA per week for a period of a few weeks following this event.

Table 2. Overview of Psychiatric treatments and frequency of different types of admissions and appointments with clinicians

	Year 1 2008	**Year 2 2009**	**Year 3 2010**	**Year 4 2011**	**Year 5 2012**	**Year 6 2013**	**Year 7 2014**
Clinical admissions	1	1	2	1	0	0	0
Total number of nights of clinical admissions.	112 nights	10 nights	15 nights 30 nights	7 nights	0	0	0
Structured day treatment, 4 days a week.	Start September 2008	Continue	Stop June 2010				
Number of appointments with psychiatrist	During admission to clinic	6	23	24	11	19	10
EMDR therapy, number of appointments with psychologist	0	0	25 for treatment of complex trauma as consequence of sexual abuse in past	4 for treatment following sexual assault on street	0	0	0
Number of Brief Admissions	**0**	**0**	**57**	**14**	**7**	**10**	**7**
Duration of nights of the Brief Admissions	**0**	**0**	**1**	**1**	**1**	**1**	**2/3**
Number of Chair on Request	**0**	**0**	**0**	**70 evenings spent at clinic**	**86 evenings spent at clinic**	**32 evenings spent at clinic**	**9 evenings spent at clinic**
Community psychiatric nurse, number of appointments	0	?	44	43	43	48	37
STEPPS course sessions	0	0	0	20 (weekly)	20 (weekly)	0	0
Illness Management and Recovery training	0	0	0	0	0	0	45 (weekly)
Daily Activity Centre, 2 days a week.			Start June 2010	2 days a week	2 days a week	2 days a week	2 days a week
Incidence of self-harm	Severe self-harm, frequent, weekly.	Serious, frequent, weekly.	Less frequent, monthly	Frequent following sexual assault.	Increase during STEPPS course because patient feels more emotion. Increase after sexual assault on street.	Self-harm in form of wounding and not eating.	One occasion of self harm (when psychiatrist mentioned end of treatment).

	Year 1 2008	**Year 2 2009**	**Year 3 2010**	**Year 4 2011**	**Year 5 2012**	**Year 6 2013**	**Year 7 2014**
Incidence of suicidal thoughts	Serious, frequent.	Serious, frequent, weekly.	Less frequent, monthly.	Frequent following sexual assault on street.	More prevalent during STEPPS course	Less frequent, monthly.	One occasion of suicidal thoughts.
Luxating life events	News that niece has been sexually abused.	Seeing stillborn baby of relative brings own history of abuse and miscarriage to the surface.		Sexual assault on street. Crisis in relationship.	Another sexual assault on street		

An overview of the psychiatric treatment of Mrs. Peters, the frequency of various admission types—including brief admissions—and appointments with clinicians is presented in Table 2. Frequent use was made of BAs in 2010 (57 times). The ward nurse reported that when Mrs. Peters used a BA for more than one night, her self-care clearly regressed. For this reason, it was decided to limit the duration of a BA of Mrs. Peters to a maximum of one night during 2010 to 2012.

Course of Brief Admissions During Treatment Phase 2. Both Mrs. Peters and the ward nurse reported that Mrs. Peters initially did not have sufficient self-esteem to consider herself worthy of help and therefore request a BA. It was also hard for Mrs. Peters to request a BA in timely manner and thereby prevent NSSI; the request for a BA usually came from the spouse or the community psychiatric nurse. One of the reasons for advising the use of BAs was to prevent NSSI and, later, to prevent a crisis in conjunction with EMDR treatment.

Mrs. Peters told us that she had problems making contact with the nurses during a BA. Her manner of communicating that she was having problems was to frequently stroll around the nursing office with her headphones on; she could not explicitly ask for attention or some interaction. As she put it, she did not have the words yet to describe her inner world. Fear and distrust of the sometimes unfamiliar nurses on the ward frequently prevented her from entering into a conversation with them. She was afraid that unfamiliar nurses would not take her seriously, on the one hand, and did not dare to share her feelings of vulnerability, on the other.

The ward nurses helped Mrs. Peters get into contact with them by starting casual conversations with her, themselves, and by explicitly planning conversations during the BA. As an outcome of these casual conversations, the initially high levels of anxiety, tension, and distrust gradually declined. When Mrs. Peters was eventually able to share her thoughts and feelings and also feel heard and understood, she became much more relaxed and was able to take care of herself again.

The Use and Functions of Brief Admissions During Treatment Phase 3

In Phase 3 of her treatment, Mrs. Peters participated in a course designed to address the problems of emotion and behavior regulation associated with BPD (see below). This occurred during 2011 to 2013 when the primary diagnosis was BPD (Table 3).

Use of BAs and STEPPS Course for Emotion Regulation. In 2011, treatment for the symptoms of the BPD was initiated in the form of a STEPPS (systems training for emotional predictability and problem solving) course (Blum et al., 2008). As can be seen from Table 2, this was combined with pharmacotherapy, supportive contact with the community psychiatric nurse, and the BA usage. The medication quetiapine was added to the medication already taken by Mrs. Peters in this year (Table 1).

Table 3. Overview of presence of clinical diagnoses during four phases of treatment

Diagnoses	Phase 1 Crisis (2008)	Phase 2 Treatment of PTSD (2009-2010	Phase 3 Treatment of BPD (2011-2013	Phase 4 Recovery (2014)
Axis I: Adjustment disorder diagnosis	Yes	No	No	No
Axis I: Post- traumatic stress disorder	No	Yes	Yes, partial remission	Yes, partial remission
Axis II: Borderline personality disorder	Yes	Yes	Yes	Yes
Axis III: Spina bifida with paralysis in the lower body	Yes	Yes	Yes	Yes
Axis IV: Problems with primary support group and social environment. Work problems.	Yes	Yes	Yes	Yes
Axis V: GAF score	No	60	45	45

After being sexually assaulted on the street at the beginning of 2011, Mrs. Peters experienced a recurrence of the symptoms of PTSD. She also had suicidal thoughts and symptoms of NSSI again. Four sessions of EMDR-2 treatment helped her regain some stability. In 2012, a second round of the STEPPS course was followed. During the first round, she had learned about the skills needed to regulate her emotions. Putting these into practice proved difficult for Mrs. Peters. The second round of the course provided an opportunity to practice these skills, and Mrs. Peters was indeed able to put the skills better into practice following the second round of the course.

She acquired the skills needed to deal with emotions and also negative thoughts. One of these skills was to simply ask people—her husband, a friend, or a clinician— if her negative or distrustful thoughts were only in her mind or had some basis in reality (i.e., were grounded). These conversations were reported to effectively help Mrs. Peters get rid herself of feelings of distrust, tension, and fear.

During this time, she also formulated a crisis plan. This included actions such as relaxation exercises and, when needed, a request for a BA.

Course of the Brief Admissions During Phase 3. During Phase 3, the following goals were added to the goals of Phase 2: preventing treatment dropout (e.g., EMDR, STEPPS course) and to practice with newly acquired skills.

Mrs. Peters was increasingly able to call the clinic ward on her own to request a BA and explain her need for it during Phase 3 of her treatment. Among the reasons for requesting a BA were conflict with her husband, death of a relative, struggling with emotions during the STEPPS course, and onset of PTSD symptoms following a sexual assault.

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Because of the consistently high number of BAs requested by Mrs. Peters and difficulties with the somatic care that she required for the physical handicaps and also the fact that she did not sleep well at the clinic, an alternative care construct was created. In 2011, another intervention, namely the "Chair on Request" (COR), was introduced. Mrs. Peters was now able to be at the clinic 3 evenings a week. She could come at 19 hours and leave for home at 21 hours. Both interventions, brief admission and COR, could be used during this phase.

In 2011, Mrs. Peters used BA a total of only 14 times and the COR a total of 70 times. In 2012, she used BA 7 times and the COR 86 times. And in 2013, she used BA 10 times and the COR 32 times (Table 2). When using a BA, Mrs. Peters had to arrange for the community somatic nurse to help her at the clinic with her bathing and catheter. Mrs. Peters arranged this perfectly each time. In 2013, Mrs. Peters requested that the duration of the BA be expanded from 1 to 2 or 3 nights in order to allow her to relax more. This request was accepted because her selfcare went so well during the BAs at this time.

Practicing Newly Learned Skills During Brief Admissions. Mrs. Peters was increasingly able to express her need for a conversation to a nurse at the clinic during her BAs. She would explain that she needed to tell her story to someone and thereby lessen the level of tension being experienced. Mrs. Peters was able to prevent the occurrence of NSSI by doing so.

Mrs. Peters also practiced with her newly acquired STEPPS skills during her BAs. When talking to nurses, she worked to reflect on her inner world and was increasingly able to describe her current thoughts and feelings. By doing this, she was also able to recover from a crisis sooner than was previously the case. The ward nurse described how she would let Mrs. Peters first tell her story and then they would explore the situation to identify the trigger for the current crisis. The nurse also reported discussing with Mrs. Peters what Mrs. Peters could do, herself, to solve the crisis; just how she had reacted in the situation; and what she might do differently when confronting such circumstances in the future. It was made clear that the responsibility for solving the problems remained that of Mrs. Peters.

The Use and Functions of Brief Admissions During Treatment Phase 4

The *DSM-IV* classification stayed the same for Mrs. Peters in 2014, namely, BPD (Table 3). Reduced occurrence of the symptoms of PTSD and BPD allowed her medication to be cut to trazodone, haloperidol, topiramaat, lorazepam, and fluoxetine (Table 1).

Mrs. Peters further worked on her recovery during this phase of treatment by following an Illness Management and Recovery course (Mueser et al., 2002). This was combined with pharmacotherapy, support from the community psychiatric nurse, and continued use of BAs as needed. During the course, Mrs. Peters learned to live with her illness

better, accept her vulnerability, and thereby dare to feel her emotions more. All of this allowed her to more frequently prevent a crisis by requesting help in time (e.g., when she experienced heightened tension or anxiety).

Mrs. Peters actively expanded her daily activities with the addition of volunteer work. She added working as an experience expert for a patient shelter to her work as a volunteer at a retirement home.

Course of the Brief Admissions During Phase 4. The frequency of BA usage further decreased. BA was used a total of 7 times in 2014 and a COR was used a total of 9 times (Table 2). It was important to prevent the occurrence of a crisis from interfering with the social roles and obligations that Mrs. Peters had taken on. During Phase 4, the following goal was added to the goals of Phase 3: to support her social functioning by offering her an assuring environment when her social roles increased feelings of tension.

Although now rare, Mrs. Peters still experienced a crisis on occasion and needed psychiatric help. She described the course of such a crisis as follows. She first feels alone and some despair or rejected by others in a social context. As a result, she rejects—in turn—those who are close to her and her husband in particular. Anxiety occurs as a result of increased feelings of being isolated and an increased fear of abandonment. A need to relieve extreme tension arises and NSSI can then occur. When taking extra medication to calm down does not help, Mrs. Peters can request a BA to prevent the possibility of NSSI. Mrs. Peters continues to experience the clinic as a safe and assuring environment due in part to the presence of a nurse 24 hours a day. Her conversations with a nurse bring relief and allow her to relax. She now reports daring to share her emotions during such interactions and ability to ask the nurses if her distrustful thoughts are grounded or not. Mrs. Peters reports experiencing mutual trust with the nurses at the clinic now. Since Mrs. Peters is able to take the responsibility for managing her own crisis, it is notable that she expanded her social roles and activities as part of her personal recovery.

DISCUSSION

The purpose of the study was to characterize the use of the intervention BA in a single case study involving a 7-year treatment period for a patient suffering from severe psychiatric issues, with a predominance of symptoms of BPD and a complex PTSD. In every phase, new goals of the BA were added to the previous ones. The main goal during the initial phase of treatment was to prevent suicide and NSSI. This goal could not be met by long-term inpatient admissions, even in spite of the patient's wish for long inpatient admissions on several occasions. Unplanned or long-term hospitalization of patients with BPD in a general psychiatric setting has proven to have limited value

and negative side effects; regression, repetitive admission, and non-recovery from chronic suicidal ideations following discharge are often found (Paris, 2004). These side effects were observed in the patient case discussed here as described in Phase 1 of the treatment, and were the reason for starting with the BA intervention.

New goals of the BA were added during subsequent phases of treatment, namely, prevention of long admissions, prevention of dropout from therapy, offer opportunities to exercise newly acquired skills, offer opportunities to expand autonomy and self-care, and—finally—establish preconditions needed to maintain social roles. The same goals for the use of BAs were mentioned in a previous phenomenological study in which 17 patients were interviewed (Helleman et al., 2014b).

The clinicians in the case described here reported that the use of BAs greatly facilitated communication with the patient during a crisis. The intervention helped shift the patient from a position of dependency and inexplicit communication into a position of active, autonomous functioning with explicit communication, and discussion of key issues was now possible. By the end of the 7-year period of treatment, the patient could consider and answer questions such as, “What has upset you?” and “How can a BA help you regain control over your symptoms?”

In the course of treatment for the patient reported here, the BA intervention was used alongside other types of therapy including individual psychotherapy, group therapy, repeated participation in a STEPPS course, and EMDR treatment. This is in keeping with the *Dutch Multidisciplinary Guideline for Personality Disorders* (2008). The guidelines from the U.K. National Institute for Health and Clinical Excellence (2009) similarly describe the importance of helping patients increase their autonomy by giving them opportunities to learn and practice with the skills they need to prevent or act during a crisis and thus prevent NSSI or suicide. BAs offer one such learning opportunity. The patients themselves decide on the start of a BA and not the clinicians. Extension of a BA is not possible given the limited timeframe of the intervention, as its briefness is essential to this intervention and sets it apart from regular hospitalizations.

Strengths and Limitations

As far as we know, this is the first study that describes the journey of a patient for a prolonged time, using the BA as part of her treatment. We were able to interview all the clinicians who were involved with the patient during this period and provided an in-depth and detailed description of the value of the BA.

The limitation of the present study is that it was a single, descriptive case study. This means that the results may not hold for other patients or other settings (limited generalizability). Furthermore, it is possible that the subjective perspectives of those conducting the research may have influenced data collection (researcher bias). The retrospective nature of the interviews and thus data collection may also have allowed for some selective recall (recall bias). With the use of multiple informants and chart

reviews and thus data triangulation we tried to prevent bias. Finally, the outcomes of BA usage cannot be separated from overall treatment outcomes. All the informants in this case study, however, positively viewed the use of BAs for the prevention of self-harm and suicide.

Conclusions

The BA intervention positively influenced the treatment course for a patient with diagnoses of BPD and PTSD. The goals and use of BAs clearly differed for the different phases of treatment and developed from the prevention of self-harm or suicide, long admission, and dropout from therapy to offering opportunities to practice with newly acquired skills for emotion and behavior regulation to expansion of autonomy and establishment of the conditions needed to maintain social roles.

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Chapter 5

Brief admissions for patients with a Borderline Personality Disorder in the Netherlands: Different setting, different intervention? A descriptive study

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ABSTRACT

Background: Brief admission is a crisis intervention for patients with borderline personality disorder (BPD), and refers to a clinical admission at a psychiatric hospital for a period of 1-5 nights. Patients formulate a treatment plan together with their community mental health nurse about the maximum frequency allowed for these brief admissions. Its use is more practice based and determined by consensus rather than evidence based. The purpose of the present study was therefore to describe the organization of brief admission in The Netherlands and to describe the similarities and differences found to date in the protocols provided by organizations using brief admission as an intervention for patients with borderline personality disorder.

Methods: A descriptive study of the content of 41 protocols for use of the intervention Brief admission at 33 mental health care institutions. Content analyses were conducted using a list of 22 items, based on the results of two previous studies, to guide data extraction.

Results: In 34 of the 41 protocols analyzed, a brief admission treatment plan was developed with the patient prior to the occurrence of a crisis and included in the patient's overall treatment plan. The maximum frequency of brief admissions allowed by the institution ranged from 4 times a month (n=6) to once a month (n=1), or an individually determined frequency tailored to the patient's specific needs (n=16). In more than half of the 41 analyzed protocols, it was stated that the patient could call the ward directly when in crisis to request a brief admission (n=23).

Conclusions: Brief admission is a potentially helpful intervention but needs more development. Although widely used in the Netherlands, the organization and implementation of brief admission was found to be very heterogeneous when used to help patients with borderline personality disorder. Different settings appeared to lead to different interventions.

BACKGROUND

Borderline personality disorder is characterized by interpersonal hypersensitivity, a fearful preoccupation with expected abandonment, and intense but unstable interpersonal relationships (Gunderson et al., 2011). Other characteristics are affective instability, inappropriate intense anger, poor impulse control, suicidal and self-mutilating behavior (DSM-IV, 2000), chronic feelings of emptiness, identity disturbences and paranoid or dissociative symptoms (Bender & Skodol, 2007).

Patients with borderline personality disorder typically receive outpatient psychotherapy, which may be dialectical behavior therapy (Linehan, 1993), mentalization-based treatment (Bateman & Fonagy, 2009), schema focused therapy (Giesen-Bloo et al., 2006), transference focused therapy (Clarkin et al., 2006), or some other form of therapy. Patients may also need pharmacotherapy, psychosocial support, and crisis intervention for suicidal thinking or deliberate self-injury at times (Cleary et al., 2002). One frequently used crisis intervention is the brief admission. Brief admission is a crisis intervention and refers to a clinical admission for a period of 1–5 nights. A BPD treatment plan is then formulated to include the maximum frequency of using these brief admissions (Helleman et al., 2014a). Brief admission was introduced in the 1980s when the opinion spread that long admission could lead to regression in patients with borderline personality disorder (Paris, 2004; Krawitz et al., 2004). Successful discharge of patients following a long-term stay on the general psychiatric ward of a psychiatric hospital was found to be quite difficult for patients with borderline personality disorder. Brief admissions, in contrast, were found to be quite helpful and cause fewer discharge problems. A brief admission can also be used to avoid interruption of the ongoing psychological treatment of patients with borderline personality disorder in times of crisis or potential crisis.

According to the Dutch Guideline for the Treatment of Patients with Personality Disorders (Dutch multidisciplinary guideline for personality disorders, 2008), brief admission is indeed helpful when patients are in crisis. Although brief admission is now used frequently worldwide, its use is more practice based and determined by consensus rather than evidence based (Helleman et al., 2014). Empirical research on the use of brief admission is generally lacking. Professional standards for the use of brief admission are also absent. The recent Cochrane review (Borschman et al., 2012) on the evidence for the effectiveness of crisis interventions for patients with a borderline personality disorder found no RCT-based evidence for the management of acute crisis in patients with a borderline personality disorder.

The variation in the operationalizations of brief admission is unknown. Insight into this variation is pivotal for documenting the effectiveness of brief admission and obtaining consensus on the underlying mechanisms and critical content. The purpose of the present study was therefore to describe the organization of brief admission in The Netherlands and to describe the similarities and differences found to date in the

protocols provided by organizations using brief admission as an intervention for patients with borderline personality disorder.

METHODS

In this descriptive study, the content of protocols for brief admission interventions used in the Netherlands was analyzed. The need for approval of an institutional review board (IRB) was waived because no patients or staff were involved in the study.

Setting

In the Netherlands, individuals in an acute mental health crisis can be admitted to three types of mental health care institutions: a) the psychiatric wards of university hospitals (n=8); b) the psychiatric wards of general hospitals (n=38); or c) the acute care wards of specialized mental health care institutions (n=35). This comes to a total of 81 organizations providing acute mental health care in the Netherlands. It is common practice for the standard procedures used at these institutions to be described in protocols.

Sample

The 81 Dutch mental health care organizations providing acute mental health care, had a total of 102 admission wards which were approached by letter, email and/or telephone between April 2011 and March 2013. They were asked if they used a brief admission intervention and, if so, if they would then be willing to supply us with a copy of their brief admission protocol(s).

Inclusion criteria were: use of brief admission intervention and protocol for brief admission intervention available. 52 wards were excluded from our study because they did not use brief admissions. An additional 9 wards were excluded because they used brief admissions but had no protocol for doing this. In the end, thus, 41 wards from 33 mental health care organizations were included in our analyses.

Data extraction

Drawing on the results of two previous studies, we composed a list of items to guide the extraction of data (Table 1).

The first study was a review of the literature which identified five core components.

- discussion of the goal of the brief admission with the patient in advance,
- notation of the brief admission procedure in a written treatment or crisis plan,
- clear understanding of admission procedure and duration of the brief admission,
- description of the interventions used during the brief admission, and
- specification of the conditions for premature discharge.

The second study was a qualitative study of patient experiences with the use of the brief admission (Helleman et al., 2014a). The following points were considered in that study:

- discussion of goals of the brief admission with the patient,
- writing of a brief admission treatment plan,
- accepted frequency and duration of the brief admission,
- description of the admission procedure,
- description of interventions used during brief admission,
- specification of conditions for premature discharge, and
- organization of the brief admission on the ward.

Based upon these results 22 items were identified (Table 1). The reliability of data extraction was checked by having two of the authors use the available coding categories to score the items independent of each other. Discrepancies were discussed until consensus could be reached.

Table 1. 22 items and response options used to analyze protocols for Brief admission at 41 admission wards.

Items	Response options
Development of the Brief admission treatment plan	
1. Is the goal of the brief admission intervention described?	Yes n=36 No n=0 Not known n=5
2. Is there usage of a brief admission treatment plan?	Yes n=34 No n=0 Not known n=7
3. Is the brief admission treatment plan part of the overall treatment plan?	Yes n=26 No n=1 Not known n=14
4. Is the brief admission treatment part of the crisis plan for the patient?	Yes n=22 No n=0 Not known n=19
5. What is the frequency of brief admissions accepted by the ward?	Frequency of 4 times per month n= 6 Frequency of 2 times per month n=0 Frequency of 1 time per month n=1 Individual policy n=16 Not known n= 18.
6. What is the accepted duration for the Brief admission by the ward?	Duration of 8 hours. n= 2 Duration of 24 hours (1 night) n=10 Duration of 48 hours (2 nights) n=8 Duration of 72 hours (3 nights) n=6 Individual policy n=9 Not known n= 6
7. Is there an intake interview prior to the brief admission?	Intake with patient, outpatient clinician, and nurse from the clinic. n=4 Intake with patient, outpatient clinician, nurse from the clinic, and psychiatrist from the clinic. n=5 Intake with patient and nurse from the clinic. n=5 Not known n=27

Items	Response options
Admisson procedure	
8. Is it possible for the patient to call directly to the ward for a brief admission?	Patient can call directly to the clinic n=23 During office hours, patient should contact own clinician; outside office hours, patient can call directly n=10 Patient must contact their clinician n=6 Not known n=2
9. Is there an interview at point of brief admission?	With nurse from the clinic. n=13 With nurse and psychiatrist from the clinic. n=5 Not known n=23
Description of interventions used during Brief admission	
10. Is there a description of the interventions used during a brief admission?	Yes n=37 No n=4
11. Can patients request consultation/conversation with nurses during brief admission?	Yes n=13 No n=28
12. Is the patient responsible for own medication during brief admission?	Yes n=16 No n=8 Individual policy n= 1 Not known n=16
Specification of conditions for premature discharge	
13. Policy on the topic of self-harm	Not allowed n=16 Individual policy n=4 Not described n=21
14. Policy on the topic of aggression	Not allowed n=17 Individual policy n=4 Not described n=20
15. Policy on the topic of alcohol and/or drug use	Not allowed n=17 Individual policy n=3 Not described n=21
16. Policy on the topic of attempted suicide	Not allowed n=14 Individual policy n=4 Not described n=23
Indications and contra-indications for Brief admission	
17. Indication for brief admission	Patient is diagnosed with a borderline or other personality disorder, has symptoms such as anxiety, and is at risk of auto-mutilation and/or suicide. n=10 Prevention of decompensation and crisis by offering a safe place to stay. n=12 Easing the burden on family or partner of the patient when it has become impossible to support and care for the patient at home. n=3 Not known. n=16
18. Contra-indication for brief admission	Patient is already experiencing a crisis accompanied by destructive behavior such as auto-mutilation, intoxication, and/or attempted suicide. n=11 Primary addiction problems and alcohol-drug intoxication. n=11 Psychiatric crisis with need for long-term clinical treatment or forced admission. n=4 Problems that are not primarily psychiatric but social, like homelessness. n=2 Threat of violence at moment of admission. n=2 Psychotic disorders. n=1

Items	Response options
	Patient cannot commit to brief admission plan. n=2 Not known. n=20
Organization of the Brief admission on the ward	
19. Who is responsible for policy with regard to patient during brief admission?	Outpatient clinician n=14 Psychiatrist from ward n=11 Not known n=16
20. Location of brief admission	Mental health care institution ward n=27 Room outside mental health care institution ward n=2 General hospital ward n=10 University hospital ward n=2
21. Does evaluation take place at the end of the brief admission either at the clinic or with the outpatient clinician?	Yes n=29 No n=0 Not known n=12
22. Is there a theoretical background to the care for patients with a borderline personality disorder during a period of brief admission described?	Yes n=10 No n=31

Data analyses

After reading the 41 protocols, scoring categories drawing on the content of the protocols were formulated by the authors for each of the 22 items of interest. Each protocol was then scored using the scoring categories (see Table 1).

RESULTS

Development of brief admission treatment plan

In 34 of the 41 protocols we analyzed, There was usage of a brief admission treatment plan. The central goals mentioned in most of the brief admission protocols were: prevent crisis and the need for long-term admission; prevent deliberate self-injury or suicidal acts; restore day/night structure and self-care; and prevent drop-out from outpatient psychotherapeutic treatment. In the remaining 7 protocols, a brief admission treatment plan was not mentioned. In 26 out of the 34 protocols, the brief admission treatment plan was embedded in the patient's overall treatment plan. In 22, the patients had a crisis plan which included brief admission intervention as an option to prevent escalation.

Accepted frequency and duration of the brief admission

The maximum frequency of brief admission allowed by the institution ranged widely from 4 times a month (n=6) to once a month (n=1) to an individually determined frequency tailored to the patient's specific needs (n=16). Of the 41 protocols, 18 did not mention a maximum frequency.

The maximum duration of the brief admission also ranged widely from 8 hours (n=2) to 24 hours (n=10) to 48 hours (n=8) to 72 hours (n=6). In 9 protocols, there was no statement of a maximum duration as the brief admission was tailored to the individual

needs of the patient. In 6 protocols, there was no specification whatsoever of the maximum duration of the brief admission.

Admission procedure

In more than half of the 41 analyzed protocols, it was stated that the patient can call the ward directly when in crisis to request a brief admission (n=23). In such cases, it was the responsibility of the patient to decide on using this intervention possibility in light of the maximum frequency allowed, the severity of symptoms, and other factors. In an additional 10 protocols, it was stated that the patient should contact their clinician during office hours or the ward after office hours to discuss a brief admission. In 6 of the protocols, it was explicitly stated that the patient must have approval of their outpatient clinician for a brief admission.

Specification of conditions for premature discharge

Half of the protocols included clear policies on such behaviors as self-injurious acts (n=20), aggressive acts (n=21), use of alcohol or drugs (n=20), or attempted suicide (n=18) during the brief admission. In these protocols was stated that occurrence is prohibited and the behavior will result in discharge. In 4 of the protocols, arrangements were made for the individual patient with regard to these behaviors.

Indications for a Brief admission

In 16 of the protocols, the indications for brief admission were not mentioned. In the other 25 protocols, the following indications for brief admission were mentioned: diagnosis of a borderline or other personality disorder with symptoms such as anxiety and a risk of auto-mutilation and/or suicide (n= 10); prevention of decompensation and crisis by offering a safe place to stay (n=12); and easing the burden on family or partner of patient when it has become impossible to support and care for the patient at home (n=3).

Prerequisites for Brief admission

In 11 of the protocols, specific prerequisites for a brief admission were not mentioned. In the other 30 protocols, it was stated that the patient must be in the care of the institution providing the brief admission. The protocols also stated that the patient should be receiving psychotherapy, community treatment, or day care treatment for a borderline personality disorder (n=17). In 7 protocols was the need for a crisis plan with explicit mentioning of the option of a brief admission stated. Also, the patient should have been capable of recognizing an impending crisis and asking, accordingly, for help in time to prevent crisis and self-destructive behavior. Some protocols (n=5) stated that patients must also be able to adhere to the agreements made as part of the crisis plan

and ward rules with regard to aggression, auto-mutilation, and suicide . Finally, one protocol mentioned patients must be able to return home following brief admission.

Contra-indications for Brief admission

In 20 of the protocols, there was no mention of possible contra-indications for brief admission. In the other 21 protocols, the following were mentioned as possible contra-indications: patient already experiencing a crisis accompanied by destructive behavior such as alcohol-drug intoxication, auto-mutilation, and/or attempted suicide; psychiatric crisis with a need for long-term treatment or forced admission; psychotic disorder and/or problems that are not primarily psychiatric but more social (e.g., homelessness) or threat of violence at moment of consideration for brief admission. Auto-mutilation and suicide attempts are very common in this population, it is one of the nine diagnostic criteria. Patients are excluded from treatment on the basis of such behaviours.

What interventions are used during Brief admission?

No mention of the interventions used during a brief admission was made in 4 of the protocols. In another 4 protocols, it was stated that an individualized plan should be made with the patient upon admission with regard to the interventions to be used during the brief admission. In the other 33 protocols, the interventions were outlined as part of the individual patient's crisis plan and thus tailored to the needs of the patient. These included taking breaks, getting enough rest, and undertaking relaxing/distracting activities like walking, drawing, listening to music, or calling a friend. When the patient is well known to the clinic, the intake interview can be conducted by a nurse from the clinic without a psychiatrist present (n=13). During the interview, the following topics should be addressed: the goals of the brief admission and what actions the patient should undertake from his or her crisis plan to achieve the agreed upon goals. Mutual expectations, agreements, and responsibilities with regard to medication should also be discussed.

On some wards, patients followed a therapeutic day program and thus participated in creative therapy or psycho-motoric therapy. On other wards, the patients were not allowed to follow a therapeutic day program. Most of the wards offered daily conversation/consultation with a nurse to provided support and allowed the patient to express emotions, anxieties, and thoughts. It was nevertheless the responsibility of the patient him/herself to arrange for such a conversation. The nurses observed the daily functioning of the patient with regard to sleep, activity, psychiatric symptoms, and self-care.

DISCUSSION

Mental health institutions in the Netherlands deliver the intervention brief admission on a large scale. Yet, the brief admission intervention is still unstandardized. Different mental health care institutions have different protocols for brief admission. The variation revealed in our analyses of 41 protocols suggests that the brief admission intervention is adjusted to the specifics of each institution, the different admission procedures used by different institutions, and differing ward cultures.

Brief admission: Interruption or part of treatment?

A description of the function and significance of a brief admission within the overall treatment strategy for patients with a borderline personality disorder was lacking in 31 of the protocols. It appeared that the brief admission intervention was developed and implemented more or less autonomously by a particular ward. In only 3 of the 41 admission wards examined in our study the brief admission intervention was embedded in a specialized treatment program for patients with borderline personality disorder. Differences in the visions on the delivery of brief admission can thus arise within and across institutions and outpatient teams. When the use of a brief admission intervention is not embedded in a more general treatment plan for a patient, moreover, it then only represents an emergency solution and therefore not a strategic intervention instrument. In contrast, when the use of a brief admission intervention is clearly embedded in the more general treatment plan for the patient with a borderline personality disorder, a clear indication will be given for when a brief admission is called for and when it can be expected to help prevent dropout from treatment (Koekkoek et al., 2010). Mutual agreement on the delivery of brief admission can further improve the connection between institutions and outpatient teams to enhance the quality of mental health care in the end and, as called for by Fanaian et al. (2013), promote a more integrated and collaborative, whole-service approach to mental health care in the community — a practice that is often still lacking. In some areas, a major culture shift in the thinking of professionals and a reorganization of the services provided may be necessary facilitate the organization and integration of brief admission into mental health care.

Who is in charge? The patient or the clinic?

The protocols we analyzed revealed a struggle between policies of control and constraint, on the one hand, and more client- and autonomy-oriented policies, on the other hand. Most wards discharge patients when they show complex destructive behaviors (e.g. auto-mutilation) that are nevertheless a part (i.e., symptoms) of their disease. This suggests that the rules and regulations of an institution may stand more central than the mental well-being of the patients it aims to help. The discharge of

patients for unacceptable but disease-related behavior represents a missed opportunity to use brief admission to benefit patients in crisis.

In previous work, patients valued in-depth discussion and development of a brief admission treatment plan together with their outpatient clinician and a nurse from the clinic (Helleman et al., 2014). Jointly developing a brief admission treatment plan as described in 14 of the protocols is also supported by the work of Koekkoek et al. (2010) who showed the development of an individual brief admission treatment plan together with the patient can help to assure agreement of the patient with the plan.

Interventions during Brief admission

Large differences were found across wards in the offering of interventions as part of a brief admission. Most of the wards offered daily consultation/conversation with nurses, which our previous research has shown to be the most important aspect of brief admission for patients with a borderline personality disorder (Helleman et al., 2014). Such patients need support to recover from a crisis or pending crisis and help gain insight into the emotions and tensions that they are experiencing (Gunderson & Links, 2014). There are nevertheless wards that offer no contact with the ward nurses during a brief admission. It is questionable whether this approach can help patients with a borderline personality disorder in times of crisis or pending crisis. Contact with a ward nurse is not a “must” but, rather, something that might be beneficial for some patients under some circumstances and should therefore be an available option for brief admission patients to choose from. “No contact” as an institutional policy was nevertheless found in two of the protocols.

Developing autonomy and free choice are key factors in the treatment of patients with borderline personality disorder although this was not clearly visible in the protocols for the use of brief admission with such patients. Patients with a borderline personality disorder should be actively involved in the finding of solutions for their problems — even when they are in crisis (Gunderson & Links, 2014; NICE clinical guideline 78, 2009). There are several components of brief admission as a therapeutic intervention that provide patients with opportunities to act for themselves and thereby attain or regain responsibility for their own lives.

- Involvement of the patient in the development of the brief admission plan and thereby agreement on the goals of the patient, duration of the brief admission, and accepted frequency of brief admissions.
- Description of interventions that are known for their positive effects for this particular patient in the individualized brief admission plan.
- Allowing the patient to call directly to the institution for a brief admission.
- Patients’ responsibility for own medication.
- Patients evaluating every brief admission with the outpatient clinician.

Strengths and weaknesses of the study

A strength of this study is its national coverage of the Netherlands and the response rate of 100%. Response bias might have occurred if wards of institutions would have decided not to share information or protocols, but this was not the case. The specificity of the study in the Netherlands limits the generalizability of the findings. Furthermore, we analyzed documents (i.e., available protocols), and excluded 9 wards without such protocols, which probably implies that our findings are somewhat flattering as they relate to wards with more considered and explicit brief admission policies. Also, as we looked at protocols, we have yet to gain insight into actual practice and motives for specific actions. The 22 items were developed from the results of a review and qualitative research. In general the external validity from qualitative studies is weak and the review did not identify a firm body of knowledge. As a result the internal validity of the data extraction table can be questioned. The conclusion should be read in light of these limitations.

Conclusion

Although widely used in the Netherlands, the organization and implementation of brief admission was found to be very heterogeneous when used to help patients with borderline personality disorder. Different settings appeared to lead to different interventions. To establish an evidence base for the use of brief admissions, we therefore recommend the adoption of a more standardized approach with a focus on those elements that are known to improve the autonomy of patients and empower them in line with the NICE guidelines. Only then can the added value of brief admissions be formally evaluated and documented for future development and implementation.

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Chapter 6

Components of brief admission as a crisis intervention for patients with a Borderline Personality Disorder: Results of a Delphi study

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ABSTRACT

Background: Brief admission (BA) is a widely used intervention for patients with a borderline personality disorder but not yet clearly defined and still lacks clear operational standards. To fully develop this intervention, the relevant components need to be identified and clearly documented.

Objective: Obtain consensus on the components of BA as a crisis intervention for patients with a borderline personality disorder.

Design: Modified Delphi study.

Results: 100% consensus was reached for the components: "BA plan must be developed *together* with the patient" and "The BA intervention should be mentioned in the care plan for the patient"; "Not all behavior on the part of the patient has to be accepted during a BA" and "The BA can only be offered together with treatment by a community care professional".

Conclusion: Consensus on the components of BA was reached for 82 of the 90 components. This indicates a substantial degree of agreement on what BA should entail.

INTRODUCTION

Borderline personality disorder (BPD) is characterized by an interpersonal hypersensitivity, marked by a fearful preoccupation with expected abandonment and intense, unstable interpersonal relationships (Gunderson, 2011). Other characteristics of BPD are affective instability, intense anger, poor impulse control, non-suicidal self-injury (NSSI) behavior (DSM-IV, 2000) and disturbances of identity and self-direction (Bender & Skodol, 2007). Furthermore, childhood disorganized attachments, separation problems, and hypersensitivity are known predictors of adult BPD (Gunderson & Lyons-Ruth, 2008). Major suffering and negative consequences for the daily lives of patients with BPD are also occur. BPD patients are high-level users of health care services, medication, social services, and psychiatric services — including ambulance and emergency care services in particular (Bender et al., 2001; Chiesa et al., 2002; Paris, 2002). Patients with a BPD have also been shown to have significantly more impairment at work, in social relationships, and at leisure than patients with a major depressive disorder (Gunderson et al., 2011; Newton-Howes et al., 2008; Skodol, 2002). And finally, a community-based epidemiological study among a sample of 859 psychiatric outpatients in the USA showed 9.3% of patients to be diagnosed with a BPD (Zimmerman et al., 2005). The median prevalence of BPD in the general population is 1.6% (Torgersen, 2009).

Voluntary brief admission to a mental health facility has proved very helpful for patients with a BPD in crisis (Berrino et al., 2011), and brief admission is now widely used. However, the use of Brief Admission (BA) as a crisis intervention is still not well defined. According to the Dutch multidisciplinary guideline for personality disorders (2008), for example, a BA at the initiative of the patient can have a positive effect. Using a BA requires that a BA treatment plan is established by the patient in consultation with a clinician *prior* to the first BA (Dutch Psychiatric Multidisciplinary Guideline Committee, 2008). The maximum number of brief admissions per year must also be stipulated as part of each patient's treatment plan. This has been seen to encourage patients to not only independently manage their brief admissions but also make careful choices with regard to treatment, treatment needs, and the use of brief admissions. The idea is that patient autonomy must be promoted.

Empirical research on the use of BA as an intervention for psychiatric patients and particularly patients with a BPD is scarce. A Cochrane review revealed a lack of sound quantitative studies on crisis interventions, including brief admissions, for patients with BPD (Borschman et al., 2012). When Helleman et al. (2014) performed a narrative review of 10 articles concerned with BA as a crisis intervention, five core components could be identified for patients with BPD: (a) discussion of the goal of the BA with the patient in advance; (b) documentation of the BA procedure in a written treatment or crisis plan; (c) clear description of the admission procedure and duration of the BA; (d)

description of the interventions used during the BA; and (e) specification of the conditions for premature discharge.

A recent phenomenological study of the experiences of 17 patients with BPD using BA for crisis prevention showed the following features to be critical: (a) organization of the BA itself; (b) quality of contact with a nurse during the BA; (c) time out from daily life provided by the BA; and (d) perceived value of the BA for the patient (Helleman et al., 2014a).

Further, the results of a descriptive study of the content of 41 protocols used for BA as a crisis intervention at 33 mental health care institutions in the Netherlands revealed a clear need for development of the intervention (Helleman et al., submitted). In 34 of the 41 protocols, a BA treatment plan was developed with the patient prior to the occurrence of a crisis and included in the patient's overall treatment plan. The maximum number of brief admissions allowed by the institution ranged from 4 times a month (n=6) to once a month (n=1) and could sometimes but not always be tailored to the individual patient's needs (n=16). More than 50% of the 41 protocols dictated that the patient could call the ward directly to request a BA in case of crisis (n=23). In such cases, it is the responsibility of the patient to request a BA and thereby prevent damage or further crisis.

In light of the above, it can be concluded that use of BA as a mental health crisis intervention tool is unstandardized in the Netherlands. Most of the protocols for the use of a BA did not include a description of the function or utility of the BA within the context of more general treatment for BPD. That is, only a few clinics outlined their vision of how use of BA as a crisis intervention can promote patient autonomy.

Given the lack of empirical research, lack of standardization, and limited information on how use of BA in times of crisis or for crisis prevention ties in with the more general objectives for the treatment of patients with BPD, the aim of the present study was to establish consensus on which components of the use of BA as a crisis intervention for patients with a BPD are crucial.

METHODS

Study design and data collection

A modified Delphi research design was used in the present study. The traditional open-ended brainstorm format normally adopted for the first round in a Delphi study was replaced by the presentation of 86 statements/items for evaluation by the panel. The items were generated on the basis of a literature review and the results of our previous research (Helleman et al., 2014, Helleman et al., 2014a). The main premise underlying the Delphi method is that the opinion of a group is more valid than the opinion of a single individual. The purpose, therefore, of using this technique is to achieve consensus among a group of experts on an issue for which there was previously no consensus (Keeney, Hasson & McKenna, 2011). The Delphi method entails two or more

rounds of questionnaire administration to the group of experts. Using this technique, a large group of otherwise geographically dispersed experts can be consulted (Campbell et al., 2003; Hasson et al., 2000; Keeney et al., 2006). An "expert" is usually defined as an "informed individual" with thus extensive knowledge of a given subject (McKenna, 1994a) or "specialist" within his/her field (Goodman, 1987).

In the present Delphi survey, consensus was sought on which components of a BA intervention are of core importance for patients with BPD. This was done using two rounds of questionnaire administration and feedback on the results between rounds (see Figure 1).

Participants

A multidisciplinary Delphi panel of psychiatrists, advanced nurse practitioners, registered nurses, and scientists from the Netherlands was formed (Table 1) . Selection of the participants occurred via purposeful sampling. The inclusion criteria for the psychiatrists, nurses, and advanced nurse practitioners were having one or more years of experience with patients with BPD in the field and experience with use of BA for crisis prevention/intervention. The inclusion criteria for the researchers were having published on the treatment of BPD. The psychiatrists, advanced nurse practitioners, and nurses working at a large mental health care organization were asked to participate in the study. Given that the organization has four clinics in four different locations with different BA protocols, different cultures, and different methods of working (Helleman et al., submitted), a broad spectrum of opinions was expected to be represented.

Questionnaire development

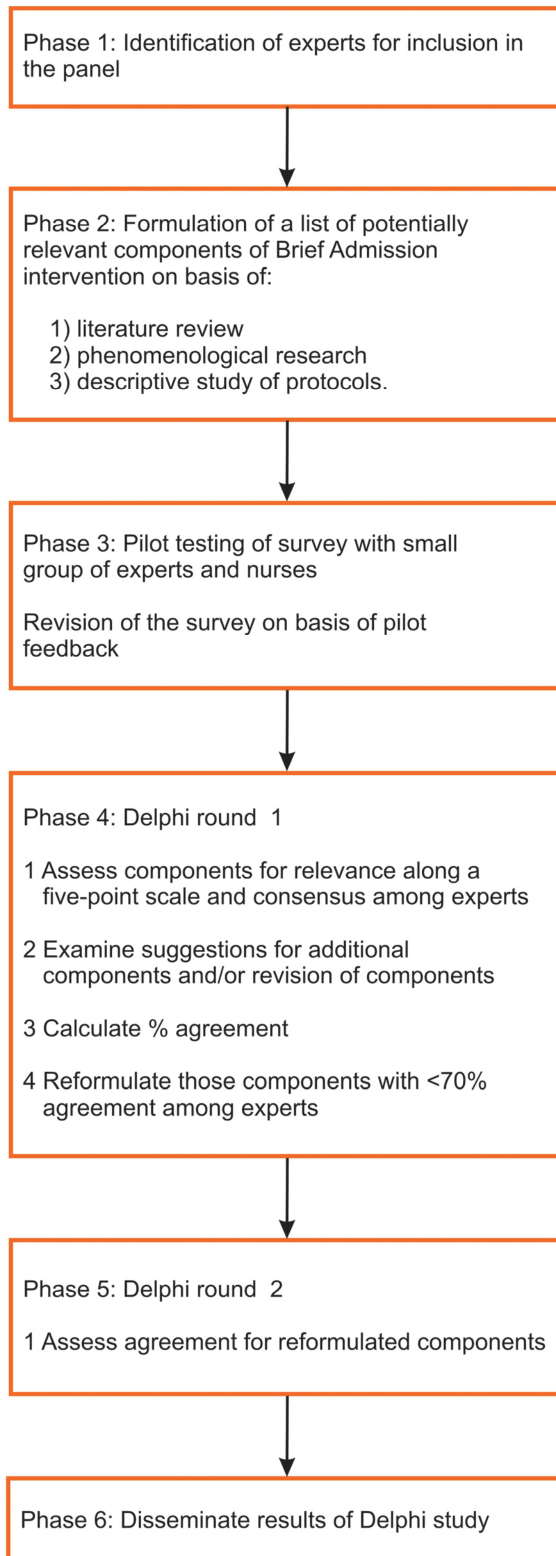
The questionnaire to be used in round 1 of the Delphi survey was based on: 1) a review of the literature to identify the relevant components for a BA (Helleman et al., 2014); the BA experiences of 17 patients with BPD reported in a phenomenological study (Helleman et al., 2014a); and the outcomes of a descriptive analysis of 41 BA protocols (Helleman et al., submitted). The questionnaire consisted of three parts: 6 demographic questions (gender, age, discipline, experience with BA, years of experience working with patients with BPD, email address); 90 statements regarding components of BA; and 16 text boxes for participants to add comments and suggest additional components of BA.

The Delphi questionnaire was pilot tested with three research experts and three nurses who did not later participate in the expert panel. The survey was adapted on the basis of the feedback provided in the pilot study.

Table 1. Characteristics of round 1 Delphi panel (n=51)

Characteristics	***n***
Gender	
Psychiatrist	
Male	n=1
Female	n=3
Advanced nurse practitioner	
Male	n=0
Female	n=5
Nurse	
Male	n=8
Female	n=31
Researcher	
Male	n=2
Female	n=1
Age (years)	Mean age:
Psychiatrist	52 (42-58)
Advanced nurse practitioner	42 (34-50)
Nurse	38 (22-63)
Researcher	45 (41-53)
Years of experience with brief admission	
Psychiatrist	
3-5 Years	n=1
5 years	n=3
Advanced nurse practitioner	
3-5 years	n=1
5 years	n=4
Nurse	
1 year	n=3
3-5 years	n=4
5 years	n=32
Researcher	
5 years	n=3

Figure 1



Ethical considerations Study approval and panel responding

The research protocol was approved by the research ethics committee at the Dimence Mental Health Care organization. Potential participants were sent information about the study in an email. When they were willing to participate, they completed the informed consent form, which was incorporated into the web survey conducted during the first Delphi round. All responses and comments were strictly anonymous although the respondents had all met the investigator in an effort to prevent dropout.

For both survey rounds, the experts were given three weeks to respond. Two reminders were sent by email to the non-responders. Thereafter, the non-responders were also reminded by telephone.

For both rounds 1 and 2 of the Delphi procedure, the experts indicated the extent to which a given component of BA was judged to be relevant along a five-point scale (1 = totally disagree that the component is relevant; 5 = totally agree that the component is relevant.

Data analysis

The survey results were analyzed using Excel sheets that allowed us to assess the degree of consensus for each survey item. After each round, the Excel sheet provided an overview of the descriptive frequencies for the items and indicated if 70% agreement had been reached or not.

The panelists were explicitly asked to provide comments and make suggestions for new items (see Table 4). Two of the researchers in the team analyzed this feedback using the MaxQdata software (VERBI GmbH, Berlin, Germany) and looked to see if any new components were suggested. It turned out that the formulation of 16 items was not sufficiently clear and therefore needed revision. Four of the 90 items showed similarity with 4 other statements in the survey during round 1 and were therefore omitted from the survey for round 2 (Table 6).

Definition of consensus

Consensus referred to the percentage of experts who agreed on a given component and thus that a statement indicated something valuable for BA. Given a five-point rating with the following categories of responding (1 = totally disagree; 2 = disagree; 3 = neutral; 4 = agree; 5 = totally agree), 70% or more of the experts assigning a score of 4 or 5 for an item was considered consensus. This cut-off point was defined at the outset of the study, in keeping with Hasson, Keeney, and Mc Kenna (2000). Only those components showing ≥ 70% agreement and thus consensus in round 1 were used in round 2 (Keeney, Hasson, & McKenna, 2011).

RESULTS

Responding for two Delphi rounds

Of the 96 experts who we approached, 74 agreed to participate. In the first Delphi round, 51 of the 74 experts returned the questionnaire (response rate of 69%). The response per group was as follows: psychiatrists 50% (n=4); advanced nurse practitioners 100% (n=5); nurses 68% (n=39); and researchers 75% (n=3) (see Table 1). In the second Delphi round, 41 of the 51 experts returned the questionnaire (response rate of 80%) (see Table 2).

For round 2 the response per group was as follows: psychiatrists 100% (n=4); advanced nurse practitioners 80% (n=4); nurses 77% (n=30); and researchers 100% (n=3) (see Table 2).

Table 2. Response rates for Delphi panel

Background	Round 1: Agreed to participate & sent survey	Completed survey	Round 2: Sent survey	Completed survey
Psychiatrists	8	4	4	4
Advance nurse practitioners	5	5	5	4
Nurses	57	39	39	30
Researchers	4	3	3	3
Total	**74**	**51**	**51**	**41**

Panel's assessment of the components of Brief Admission

Most of the items reached expert consensus (≥ 70% agreement), namely 82 out of 86 items (recall that 4 items were omitted after round 1, reducing the number of statements to 86). The 66 items achieving consensus during the first Delphi round are listed in Table 3 using the same headings as in the survey.

A consensus of 100% was reached for two items: "BA plan must be developed *together* with the patient" and "The BA intervention should be mentioned in the care plan for the patient". A consensus of more than 95% was reached for eleven other items. Eight of these were: "Patient must be able to commit to ward rules"(98%); "Before patient can make use of a BA, BA plan must be developed" (96%); "BA has to be stated as an option in the crisis plan for the patient" (96%); "Aim of the BA should be to help the patient regain control over feelings, thoughts, and problems" (96%); "Clear boundaries with regard to alcohol and drug use, aggressive behavior, self-harming behavior, and suicide attempts are important during BA" (98%); "Patients should try to keep their outpatient therapy appointments, whenever possible during a BA" (96%); "Patients should try to maintain their daily activities — like volunteer work — whenever possible during a BA" (96%); and "Clear structure and treatment clarity is important for patients with a borderline personality disorder" (98%). The other three concerned topics to be addressed in the BA treatment plan: "Aim of the BA" (98%); "Number of nights that a BA can last." (96%); and "Contact details for the ward" (98%).

Table 3. 66 items with ≥ 70% consensus found in first survey round

	Item:	**Consensus ≥ 70%**	**Outcome: Agree/ Disagree**
	Indication for Brief Admission		
1	Acute symptoms of BPD can be a reason to request a BA.	82%	Agree
2	Patient must be able to commit to ward rules.	98%	Agree
3	When a BA is requested, the patient and clinician check the patient’s crisis plan to explore and discuss alternatives to a BA.	86%	Agree
4	Family members or spouse of the patient being overburdened by care for the patient can be a reason for requesting a BA.	72%	Agree
	Contra-indication for Brief Admission		
5	When the patient is under the influence of alcohol or drugs, a BA cannot be offered.	72%	Agree
6	Homelessness or other social problems are not an indication for a BA.	82%	Agree
7	Violent or aggressive behavior constitute a contra-indication for a BA.	80%	Agree
	Preparation for Brief Admission		
8	Before patient can make use of a BA, BA plan must be developed	96%	Agree
9	The content of the BA plan should be negotiated with the patient until agreement is reached.	82%	Agree
10	The BA plan should be verified by the clinical ward prior to the conduct of a BA.	86%	Agree
11	It is important that the patient, clinic, and outpatient clinicians cooperate on the development of the BA plan.	92%	Agree
	Topics to be included in Brief Admission treatment plan		
12	Aim of the BA.	98%	Agree
13	Number of times that the patient can make use of a BA per month.	78%	Agree
14	Number of nights that a BA can last.	96%	Agree
15	Contact details for the ward.	98%	Agree
16	Name of person responsible for patient’s medication during the BA.	86%	Agree
17	Nursing approaches that the patient experiences as positive or negative.	94%	Agree
18	Reasons for possible premature discharge — like alcohol or drug use, aggressive behavior, or self-harming behavior.	94%	Agree
	Brief Admission treatment plan		
19	BA has to be stated as an option in the crisis plan for the patient.	96%	Agree
20	BA plan must be developed *together* with the patient.	100%	Agree
21	BA intervention should be mentioned in the care plan for the patient.	100%	Agree
22	BA plan should be tailored to the needs of the patient.	86%	Agree
	Goals of Brief Admission		
23	Aim of the BA should be to prevent crisis, self-harming behavior, or suicide.	86%	Agree
24	Aim of the BA should be to help the patient regain control over feelings, thoughts, and problems.	96%	Agree
25	Aim of the BA should be to prevent long-term admissions.	83%	Agree
	Admission procedure for Brief Admission		
26	Have patient be responsible for communication with the ward about BA in order to foster autonomy.	82%	Agree
27	During office hours, patient should first consult with outpatient clinician to discuss indication for BA.	84%	Agree
28	Intake conversation should occur with nurse upon arrival on ward for BA.	86%	Agree
29	During intake conversation, nurse should ask what triggered the need for a BA.	81%	Agree
30	During intake conversation, nurse and patient should discuss the BA plan and aims of the current BA.	86%	Agree
31	During intake conversation, agreements should be made on the frequency and duration of daily conversations between nurse and patient.	73%	Agree

	Item:	**Consensus ≥ 70%**	**Outcome: Agree/ Disagree**
32	If patient experiences acute feelings of despair during BA, they are allowed to ask for help.	94%	Agree
	Patient request for Brief Admission		
33	Patient is allowed to independently request a BA.	74%	Agree
34	During BA, prescribed medication can only be changed by patient's outpatient psychiatrist.	88%	Agree
35	Patient should always be seen by the ward psychiatrist when admitted for a BA.	90%	Disagree
	Conditions for premature discharge		
36	Clear boundaries with regard to alcohol and drug use, aggressive behavior, self-harming behavior, and suicide attempts are important during BA.	98%	Agree
37	After self-harm or suicide attempt, patient is discharged from BA as crisis was not prevented.	82%	Agree
	Organization of Brief Admission on the ward		
38	Patients must be able to take responsibility for their medication during the BA.	88%	Agree
39	During BA, outpatient psychiatrist remains responsible for treatment policy.	94%	Agree
40	During BA, contact with a nurse is not necessary.	76%	Disagree
	Interventions during Brief Admission		
41	Interventions for use during BA should be specified in BA plan.	92%	Agree
42	Patient should be able to request daily conversation with a nurse during BA to share emotions and thoughts.	94%	Agree
43	Emotions, thoughts, and stressors experienced by patient should be discussed during daily conversation with nurse.	84%	Agree
44	It is the responsibility of the patient him/herself to request a daily conversation with a nurse.	72%	Agree
	Contact with nurses during Brief Admission		
45	Sharing of emotions and thoughts with nurse can help patients regain control of them.	86%	Agree
46	Some patients may need help to get into contact with a nurse and it is therefore helpful if the nurse takes the initiative in such circumstances.	76%	Agree
47	Feeling safe, secure, and accepted is important for the patient during a BA.	94%	Agree
48	Patients need contact with nurses to share any feelings of anxiety, abandonment, rejection, sadness, or anger.	73%	Agree
	During a Brief Admission		
49	Patients do not attend ward therapy groups — like creative therapy or psychomotoric therapy — during a BA.	74%	Agree
50	Patients should try to keep their outpatient therapy appointments, whenever possible during a BA.	96%	Agree
51	Patients should try to maintain their daily activities — like volunteer work — whenever possible during a BA.	96%	Agree
	Time-out from daily life		
52	During a BA, patients will generally experience fewer triggers than in daily life, which can help them relax.	88%	Agree
53	Nurses can help a patient find relaxing activities during a BA.	88%	Agree
	Structure		
54	The daily structure on the ward (having coffee, eating meals) can help a patient regain control.	78%	Agree
55	If patient has trouble finding and maintaining daily activities, planning the day together with a nurse can help.	94%	Agree
56	Contact with fellow patients can be stressful. During a BA, patients must therefore) set limits for fellow patients.	80%	Agree

	Item:	Consensus ≥ 70%	Outcome: Agree/ Disagree
	Evaluation of Brief Admission		
57	BA should be evaluated before discharge together with a ward nurse on the basis of agreements made at intake.	82%	Agree
58	During evaluation of the BA, whether or not it served its purpose should be discussed.	88%	Agree
59	After BA, patient and community care professional should discuss whether the patient has managed to work on the goals of the BA or not.	86%	Agree
60	After every BA, the BA plan should be evaluated and revised as necessary by the patient together with a community care professional.	70%	Agree
	Theoretical background on Brief Admission intervention for patients with a borderline personality disorder		
61	BA can only promote patient autonomy when the patient is in charge of it.	94%	Agree
62	BA can reinforce and enhance the problem-solving skills of patients.	92%	Agree
63	BA gives patient with a vulnerability for crisis an opportunity to learn how to manage a crisis using BA.	92%	Agree
64	Clear structure and treatment clarity is important for patients with a borderline personality disorder.	98%	Agree
65	BA is one of the treatment options that can be offered to patients with a BPD.	88%	Agree
66	To make a BA a success, easy access to ward beds is necessary.	90%	Agree

Table 4 displays 16 items that did not show≥ 70% agreement during the first Delphi round but nevertheless produced agreement after reformulation and administration during the second Delphi round. Two of these 16 items reached a consensus of 100%: “Not all behavior on the part of the patient has to be accepted during a BA” and “The BA can only be offered together with treatment by a community care professional”. One of the 16 items reached a consensus of more than 95%: “Talking about self-harm should not be a taboo during a BA” (97%).

Table 4. 16 Reformulated items reaching consensus (≥ 70% agreement) in second Delphi round

	Items:	% consensus first round	% consensus second round
	Indication for Brief Admission		
1	If the community care professional is on vacation, this can be a reason for a BA. Reformulate: Given that the absence of the community care professional can sometimes predict crisis, this can be a reason to request a BA.	35%	70%
	Goals of Brief Admission		
2	A goal of the BA is to prevent patients from dropping out of therapy. Reformulation: A BA can help a patient persevere following therapy.	43%	92%
	Admission procedure of Brief Admission		
3	After the BA plan is authorized, the patient gets a walk around the ward. Reformulation: Familiarization of the patient with the ward when the patient is not in crisis but after authorization of the BA plan can decrease barriers to requesting a BA.	62%	90%

	Items:	% consensus first round	% consensus second round
4	The community care professional should attend the negotiation conversation to discuss treatment policy. Reformulation: The BA plan should be authorized by the patient, the ward nurse, and the community care professional together.	18%	80%
	Patient request for Brief Admission		
5	The community care professional must give permission for the start of a BA. Reformulation: Patients themselves can request a BA at the ward.	48%	88%
	Conditions for premature discharge		
6	You should not talk about self-harm during a patient's BA. You should redirect this to the community care professional for discussion with the patient. Reformulation: Talking about self-harm should not be a taboo during a BA.	29%	97%
	Organization of the Brief Admission on the ward		
7	The room for the patient with a BA should preferably be outside the ward. Reformulation: The room for the BA can be either inside or outside the ward.	38%	85%
	Interventions to be used during Brief Admission		
8	During a BA, the patient should be allowed to participate in the ward program, which may include meals, group activities, and therapy groups. Reformulation: A patient cannot attend ward program events, like meals or coffee breaks.	37%	70%
	Contact with a nurse during Brief Admission		
9	Contact with a nurse is an important factor for a successful BA. Reformulation: Contact with a nurse during a BA is an important means to decrease patient stress.	66%	92%
10	Without a conversation with a nurse, high levels of patient stress and emotion will not decrease. Reformulation: In addition to a conversation with a nurse, other factors such as the therapeutic milieu and provision of structure can help decrease the level of patient stress and emotion.	38%	90%
	Time-out from daily life		
11	Patients can bear their daily lives more easily, thanks to a BA. Reformulation: Thanks to a BA, patients can better endure their daily lives.	66%	85%
	Structure		
12	Contacts with fellow patients can be supportive. Reformulation: Contacts with fellow patients can be experienced as supportive.	55%	93%
13	A stay with a friend can be as effective as a BA. Reformulation: A short stay with a trusted person can be as effective as a BA.	48%	80%
	Evaluation of the Brief Admission		
14	After the BA, the ward nurse reports to the community care professional for evaluation of the BA.	64%	85%

	Items:	% consensus first round	% consensus second round
	Reformulation: After the BA, the clinic should send an email to the community care professional to inform them that the patient has made use of a BA.		
	Theoretical background on the Brief Admission intervention for patients with a borderline personality disorder		
15	A stipulation for delivery of a BA is: unconditional acceptance of the patient. Reformulation: Not all behavior on the part of the patient has to be accepted during a BA.	68%	100%
16	The BA can only be seen as an interlude in the ongoing treatment by a community care professional. Reformulation: The BA can only be offered together with treatment by a community care professional.	66%	100%

As can be seen from Table 5, only 4 items did not produce agreement during both the first and second Delphi rounds and therefore no consensus: “If a patient experiences a crisis and shows destructive behavior, a BA can help prevent further escalation of the function of the patient” (55%), “If the patient has a conflict with professional and is experiencing a crisis as a result of this conflict, BA can provide a safety net and help prevent escalation of the crisis” (58%), “An important focus during a BA is to enhance the patient’s regulation of emotion” (65%), and “For every patient with a borderline personality disorder, it should be discussed if the use of a BA could with the therapy process” (55%).

Table 5. 4 Items with no consensus (<70% agreement) in the first and second Delphi round

	Items:	% consensus first round	% consensus second round
1	If the patient is in crisis, and shows destructive behavior like self-harm, intoxication or suicide attempts, the BA has no preventive purpose anymore and should not be offered. Reformulation: If a patient experiences a crisis and shows destructive behavior, a BA can help prevent further escalation of the function of the patient.	64%	55%
	Goals of Brief Admission		
2	The goal of the BA is a time-out in a failing therapeutic relation between patient and community care professional. Reformulation: If the patient has a conflict with professional and is experiencing a crisis as a result of this conflict, BA can provide a safety net and help prevent escalation of the crisis.	24%	58%
	Theoretical background on the Brief Admission intervention for patients with a borderline personality disorder		
3	During the BA, the main focus is on enhancing emotion regulation. Reformulation: An important focus during a BA is to enhance the patient’s regulation of emotion.	42%	65%

4	Every patient with a borderline personality disorder has the right to make use of a BA. Reformulation: For every patient with a borderline personality disorder, it should be discussed if the use of a BA could with the therapy process.	10%	55%

Table 6. 4 items with no consensus (<70%) in first Delphi round and therefore merged for second round

	Items:	**% consensus first round**
1	Goal of the BA is to unburden the patient's home environment. No reformulation; merged with item 4, Table 3.	46%
	Conditions for premature discharge	
2	If a patient self-harms during a BA, it is important to talk about it during the BA. No reformulation; merged with item 6, Table 4.	69%
	Structure	
3	Participation in therapy groups on the ward can help the patient regain structure. No reformulation; merged with item 55, Table 3.	30%
	Theoretical background on the Brief Admission intervention for patients with a borderline personality disorder	
4	The clinical ward is a getaway for the patient during a BA and therefore no treatment should be offered for the patient's problems at this time. No reformulation; merged with item 52, Table 3.	50%

DISCUSSION

Although the outcomes of earlier studies (Helleman et al., 2014; Helleman et al., submitted) show variation in the practice, organization, and local policies regarding the use of BA for crisis prevention and intervention, the expert panel consulted in this Delphi study showed a remarkably large consensus on the importance of many components. More specifically, consensus was reached for 82 of the 90 components of BA when considered for patients with a BPD. The findings of Koekkoek et al. (2010) support the importance of two components of BA in particular: "It is important to develop the BA plan together with the patient" and "The content of the BA plan will be negotiated with the patient until consensus is reached". These components can prevent control struggles at admission, on the one hand, and reduce fears of treatment regression, on the other hand (Koekkoek et al., 2010).

In the present study, consensus was also reached on components pertaining to the maintenance of ongoing therapy: "Patients don't follow therapy groups on the ward during the BA, like creative therapy or psychomotoric therapy" and "The patients continue to follow their outpatient therapy appointments, if possible". This indicates a focus on helping the patient maintain their outpatient therapy and prevent dropout from this therapy. In a Swiss study by Berrino et al. (2011), in contrast, patients were offered a range of therapies during a five-day BA. Whereas the patient group in the Dutch study was already involved in outpatient therapy, thus, the patient group in the

Berrino study was referred for a BA after visiting the emergency room and thus represented a group of “new” mental health care patients.

Relevance of the components of Brief Admission for crisis intervention

The present results show great value to be attached to encouraging and reinforcing patient autonomy and responsibility, also during a BA. The Delphi expert panel agreed that using BA can only support the growth of autonomy when the patient is in charge of the BA and allowed to request the BA independently. This is in keeping with the focus on autonomy and learning to cope with a crisis found in the NICE guidelines for the treatment and management of BPD (2009). Self-referral was also recommended by service providers and service users in a Delphi study of the use of community-based services by adults with a personality disorder (Crawford et al., 2008).

Comparison of the present outcomes to those of earlier studies on BA reveals some differences. Patients, in a previous study, report contact with fellow patients during a BA to be helpful and supportive most of the time (Helleman et al., 2014a). The panel experts in the present study did not consider this contact supportive in the first Delphi round. In their comments, moreover, they mentioned the risk of over-involvement between patients and the problems that this can create given that some patients find it hard to set boundaries in their contact with others (E.g. presenting his suicidal thoughts with another patient who is also struggling with this). This raises the question of whether the experts may be overlooking the added value of perceived support by patients when they have mutual contact.

Inspection of the items for which no consensus was reached shows common dilemmas encountered in the treatment of patients with a BPD. The items concerned with self-harm and destructive behavior elicited many comments in the survey. On the one hand, it is stated that self-harm constitutes a reason for premature discharge from the BA and should therefore not be discussed further during the BA. On the other hand, professionals state that the topic of self-harm should not be taboo during a BA and therefore open for discussion. The latter standpoint is supported by the NICE guideline on self-harm (2011), which state that health care professionals working with people at risk of self-harm should aim to develop a trusting, supportive, and engaging relationship with them. A non-judgmental attitude should also be adopted to ensure that patients are fully involved in any care and treatment decision-making with the aim of fostering patient autonomy and independence as much as possible. The fact that some of the professionals think that self-harm constitutes a reason for discharge indicates a gap between mental health care guidelines and current practice. The patients themselves indicate that it is important to address such topics during a BA and be able to have an open conversation in order to reduce stress, learn how to reduce stress, and practice stress-reducing activities (Helleman et al., 2014a). The BA has been reported to serve the goal of preventing self-harm, destructive behavior, and

attempted suicide (Helleman et al., 2014). Self-harm, destructive behavior, and suicidal thoughts are all symptoms of BPD that can be present during treatment — often for a long time. For many patients with a BPD, thoughts of suicide and the urge to self-harm are always present, even during a BA. The planning of stress-reducing activities together with a nurse and daily conversations with a nurse and other patients can help ventilate thoughts and emotions, however, to relieve stress.

Study strengths and limitations

Delphi methods have known limitations such as the use of a non-randomly selected sample, bias that can be introduced via the composition of the expert panel, and no concrete guidelines with regard to the optimal number of participants or optimal number of rounds (Keeney et al., 2001). The literature suggests that two or three Delphi rounds should be preferred (Green et al., 1999). In the present study, two survey rounds seemed appropriate because we administered a questionnaire to start with; this was feasible on the basis of the available research literature and outcomes of previous studies. The avoidance of so-called "sample fatigue" which can occur when more than two Delphi rounds are conducted was also a reason for using just two and not more survey rounds. The levels of consensus reported in the relevant research literature in Delphi studies in general are between 51% and 80 % (Hasson, Keeney & Mc Kenna, 2000), but concrete recommendations for how to define consensus are not available (Keeney et al., 2001). In our study, we adopted ≥ 70% agreement between the experts as the criterion for consensus and, during the first Delphi round, 69% consensus was reached; during the second round, 80%.

A Delphi panel should be composed of individuals who have substantive knowledge of the research area, the motivation to engage in the inquiry, and the capacity to articulate their judgments (Day & Bobeva, 2005). This was achieved in the present study with the selection of a multidisciplinary panel of psychiatrists, registered nurses, advanced nurse practitioners, and researchers.

Obviously the expertise of the panel affects the quality of the outcomes attained. We thus strove to convene a multidisciplinary panel of highly qualified and experienced experts on the treatment of patients with a BPD and use of BA for mental health intervention. Due to the purposeful sampling used to form our panel, a risk of selection bias does exist. To be sure that the experts in our study were representative of the population of mental health experts in general, we documented the years of experience of the panelists (Greatorex & Dexter, 2000).

The participants in our panel were all Dutch, which means that they generally responded from a national point of view. This research can thus benefit from replication using a more diverse set of experts and diverse settings. The panel participants were all employed by a single, large mental health care organization in the Netherlands. A broad spectrum of opinions was nevertheless expected and obtained

due to the different cities, clinics, cultures, protocols, and working methods involved in the study.

We did not randomly select the panel participants, which mean that volunteer bias may have occurred. In addition, the experiences and opinions of patients were not included in this study. This could have changed the outcomes due to their specific experiences with the BA. Nevertheless, the questionnaire items were developed on the basis of patient experiences with BA, so their point of view was clearly taken into account in the research we conducted.

Finally, the drop-out rate in our study was 31% (23/74) for the first Delphi round (i.e., failure to complete the questionnaire. For the second Delphi round, it was 19% (10/51). These numbers may also have introduced some response bias into our study. The psychiatrists were less included in the panel then the other professions; not because they were not invited, but because of the high workload they were not able to participate. This also may have introduced response bias into our data.

Conclusion

Given that the starting point for the present survey was what is known from previous studies on the use of BA as a mental health intervention, the outcomes of the survey provide a solid foundation for a clear description of what BA entails and for further testing of its utility for reducing self-harm, attempted suicide, and mental health admissions in quantitative research using experimental intervention research designs.

Consensus on the components of BA as a crisis intervention for patients with a BPD was reached for 82 of the 90 components. This indicates substantial agreement among a multidisciplinary group of experts on what BA should entail. There is nevertheless room for improvement with respect to a few components, namely how to communicate with patients on the topic self-harm during a brief admission.

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Chapter 7

Discussion and conclusions

SUMMARY OF THE MAIN FINDINGS

In this final chapter, a summary of the main findings of the studies conducted is presented, followed by consideration of the findings from a wider perspective. Some core conclusions will then be drawn, recommendations for future research provide, and suggestions for actual clinical practice made.

Chapter 2 presented an overview of the literature on the key components of the use of brief inpatient psychiatric hospital admissions as an intervention for patients with a borderline personality disorder (BPD). The review of the literature conducted for this purpose resulted in the inclusion of 5 articles reporting on quantitative studies, 1 article reporting on a mixed-method study, and 4 articles reporting on qualitative studies. Five key components for the use of Brief Admissions were identified: 1) discussion of goals. 2) organization of the Brief Admission, 3) admission procedure; 4) interventions used during the Brief Admission, and 5) conditions for premature discharge.

In a subsequent study, 17 patients with BPD and experience with the use of Brief Admissions were interviewed to identify which components of Brief Admission were perceived to be important for them (**Chapter 3**). Four components from the perspective of patients making use of Brief Admissions could be identified.

- *Organization of the Brief Admission,* including: the Brief Admission treatment plan, the specific goals of the Brief Admission, the admission procedure, and having a conversation with a nurse at the start of the Brief Admission.
- *Contact with a nurse*. This component was described by patients as the most important component of a Brief Admission. Such contact is reported to help them reconnect with themselves. Via contact with a nurse, patients report feeling heard, seen, and accepted; they report feeling comfortable enough to share their vulnerabilities with the nurse.
- *Time out from daily life*. Many patients highly value being able to take a step back from their daily lives during a Brief Admission. This allows them to get some rest; gives them structure; provides them with distraction, when needed; and allows them to meet and interact with fellow patients.
- *Experienced value for the patient;* Relaxation and prevention of a total loss of control are perceived as positive aspects of the use of Brief Admissions. As patients became more experienced with their use, moreover, they reported becoming more autonomous and thereby taking greater responsibility for their recovery. The availability of a Brief Admission in time of crisis is also reported to give the patient a sense of security.

In **Chapter 4**, insight is gained into a single patient's use of Brief Admissions across a period of seven years. Four phases could be distinguished in the patient's use of Brief Admissions and psychological recovery: crisis, treatment of PTSD, treatment of BPD, and recovery. The use of Brief Admissions could be seen to positively influence the course of treatment. Brief admissions were initially used to prevent self-harm and suicide. The goals and functions of using a Brief Admission were gradually expanded to include prevention of the need for prolonged admission to a mental health facility, prevention of drop-out from evidence-based therapy, providing opportunities to practice newly acquired skills, and the promotion of autonomy.

In **Chapter 5,** the results of a descriptive study of the various protocols followed for the use of Brief Admissions in the Netherlands are reported. In the large majority of the protocols analyzed, a Brief Admission treatment plan was developed together with the patient prior to the occurrence of a crisis and thus the need for a Brief Admission. Inclusion of the Brief Admission intervention plan in the patient's overall treatment plan was also required by the most of the protocols. In half of the analyzed protocols, it was stated that the patient could call the ward directly to request a Brief Admission when in crisis (or pending crisis). The main goals of the Brief Admission mentioned in most of the protocols were: prevention of crisis and the need for long-term admission to a mental health facility; prevention of deliberate self-injury or suicide attempt; restoration of day/night structure and self-care routines; and prevention of drop-out from outpatient psychotherapeutic treatment. More than 50% of the protocols included clear policies on the occurrence of self-injurious or aggressive behavior, the use of alcohol and drugs, and attempted suicide during the Brief Admission: these behaviors are prohibited and thus grounds for discharge from the facility.

Finally, in **Chapter 6**, the results of a Delphi study undertaken to develop a consensus on the relevant components of Brief Admission when used for purposed of crisis intervention are reported. Consensus (≥ 70% agreement) was reached for 82 of the 90 components derived from the previous studies. The highest consensus levels (100%) were reached for the following components of a Brief Admission.

- A Brief Admission plan must be developed *together* with the patient.
- Brief admission intervention should be mentioned in the patient's general care plan.
- Not all behavior on the part of the patient must be accepted or tolerated during a Brief Admission.
- The Brief Admission should only be offered in conjunction with treatment by a community care professional.

A number of other components also showed high consensus (≥ 70%).

- Patient must be able to commit to ward rules.
- Before patient can make use of a Brief Admission, a Brief Admission plan must be developed.
- Brief admission has to be explicitly stated as an option in the crisis plan for the patient.
- Aim of the Brief Admission should be to help the patient regain control over feelings, thoughts, and problems.
- Specification of clear boundaries with regard to alcohol and drug use, aggressive behavior, self-harming behavior, and suicide attempts during Brief Admission is important.
- Patients should try to attend nay outpatient therapy appointments they may have whenever possible during a Brief Admission.
- Patients should try to maintain their daily activities — like volunteer work — whenever possible during a Brief Admission.

DISCUSSION OF THE MAIN FINDINGS

The results of the present research demonstrate the importance of Brief Admission (BA) as a self-management intervention for patients with BPD in crisis. The Brief Admission offers a combination of components that both patients and professionals perceive to be quite useful and effective for reducing stress, anxiety, and self-harm in patients while also promoting the growth of autonomy and development of adequate coping skills. This is in line with the National Institute for Health and Care Excellence guideline: Borderline personality disorder: Treatment and management (NICE, 2009) which emphasize the importance of allowing patients to *choose* which intervention or interventions are best for them when in crisis and to foster autonomy. In other words, a Brief Admission can only be considered a self-management intervention when the patient is *able* to request the Brief Admission themselves and the clinic can be contacted 24 hours a day (van den Reek & de Muijnck, 2015). In the study by van den Reek & de Muijnck, patients explicitly stated that they were not able to *really* learn to deal with a crisis when they were not able to contact the clinic at any time, which underlines the current findings.

The outcomes from our study on protocols for the use of Brief Admission nevertheless present a different picture for some 50% of the protocols. In contrast to what we found for patients and in the Delphi study on the most relevant components of a Brief Admission when viewed from the perspective of mental health experts, only slightly more than half of the 41 analyzed protocols stated that the patient could call the ward directly when in crisis to request a Brief Admission (n=23). In other words, almost half of the Dutch clinics chose to *not* put the patient in control of the crisis and

thus promote self-management. This despite our finding that patients clearly prefer to call to the clinic themselves and the item in the Delphi study eliciting 84% agreement among the experts: “Let the patient be responsible for communication with the ward about Brief Admission in order to foster autonomy.”

For most aspects of Brief Admission, however, a high level of internal consistency was otherwise found in the 5 studies reported on here. The literature review, studies with patients, analysis of protocols, and Delphi rounds with professionals all point to the importance of the *joint* development of a well negotiated individualized Brief Admission plan with the aid of three parties: the patient, the clinic and the community care clinician. Within this Brief Admission plan, a number of elements must be clearly articulated: the goal of the Brief Admission, the maximum duration of the Brief Admission, the acceptable frequency of use, the nature of the interventions during Brief Admission, the nursing approach preferred by the patient during a Brief Admission, and the commitment to be made by the patient during a Brief Admission (e.g., no alcohol/drug abuse), no violence, no self-harm). Also important is the imbedding of the Brief Admission plan in the overall treatment plan for the individual patient. In a randomized control trial by Borschman et al. (2013), by further example, the effectivity of a joint-crisis plan (jointly developed by clinician and patient) for the prevention of crisis among patients with a BPD was found to be limited due to the crisis intervention (i.e., joint crisis intervention plan) not being embedded in the overall treatment plans for the patients.

Another component consistently found to be important was the care for patients having thoughts of self-harm during a Brief Admission. According to both the patients and the mental health professionals in our studies, talking about thoughts of self-harm should *not* be prohibited or considered taboo during a Brief Admission. By mentioning such thoughts and talking about them, the patient can think of ways to prevent self-harm together with the nurse. However, part of the clinicians in the Delphi study consider self-harm no topic of conversation during a Brief Admission. This is not in line with the priorities mentioned in the Self-harm clinical guideline developed by the National Institute for Health and Care Excellence (2011) in Great Britain. According to this guideline, clinicians must aim to develop a trusting and supportive relationship with patients and adopt a non-judgmental approach towards the patient to ensure that patients are fully involved in decision-making about their treatment and care, and to foster patient's autonomy and independence wherever possible.

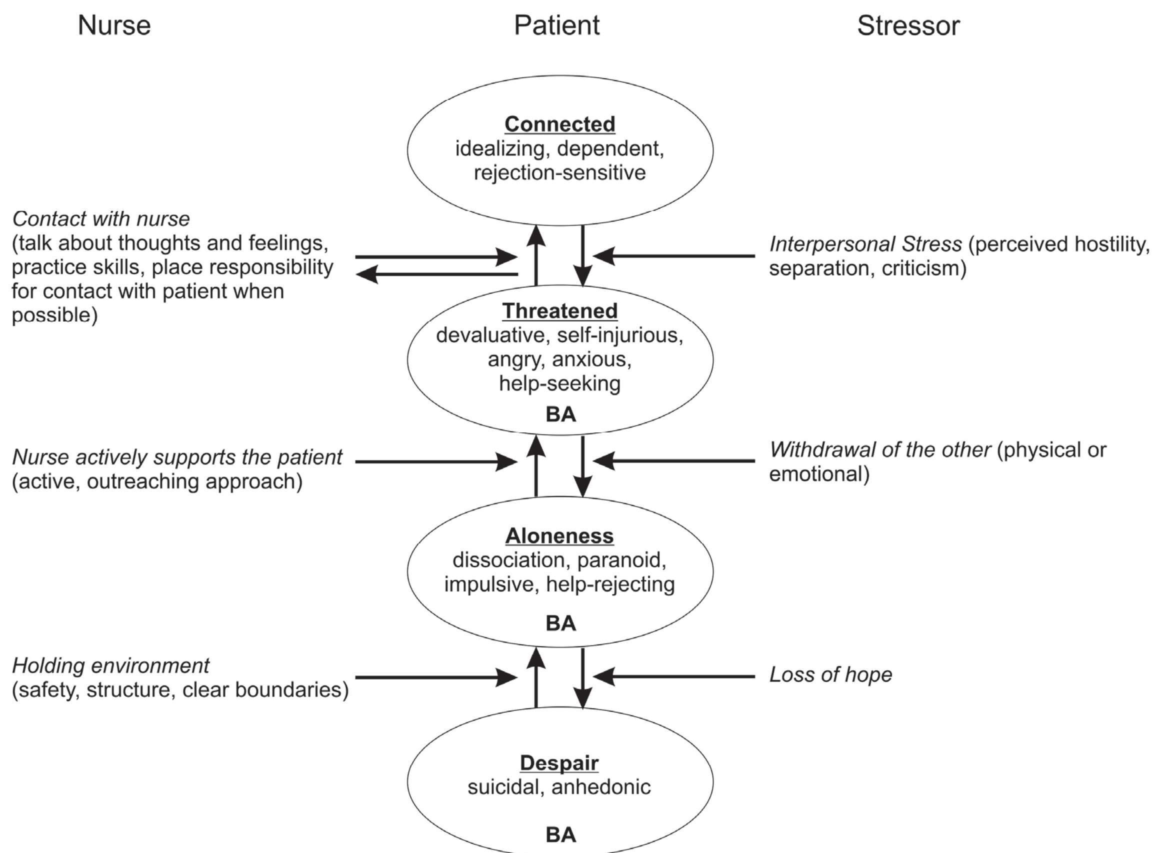
The contribution of Brief Admission to the recovery of patients with BPD in crisis

The results of our studies on the potential value and different perspectives on the use of Brief Admission for purposes of crisis intervention can be understood in terms of the work of Gunderson and Links (2014), who have attempted shed light on the manifestation of BPD. Figure 1 is based upon the theory of interpersonal vulnerability

as developed by Gunderson and Links to characterize the inner processes of patients with a BPD when interacting with others — including nurses, spouses, and family members. According to this theory, the patient's psychological functioning can quickly change from feeling "connected" (i.e., a high level of functioning) to feeling "threatened" or "alone" and even feelings of "despair" (i.e., the lowest level of functioning). Most of the crisis situations for patients with BPD indeed arise from problems with interpersonal relations mostly in the home environment. Overt or *perceived* rejection by a spouse, other member of the family, nurse, therapist, or other person of trust may make a patient with a BPD feel threatened and thereby lead to feelings of anger, anxiety, and self-devaluation but also to self-harm and help seeking.

Gunderson and Links (2014) hypothesize that patients with a BPD may thus need a "holding" environment at times with clear support and also contact to reconnect and recover from a crisis. These observations are in keeping with the outcomes of the studies reported here. Patients with a BPD report the need for a safe and holding environment, support, and contact with a nurse during a Brief Admission. In Figure 1, the results of the present research are therefore combined with the theory of Gunderson and Links to visualize what happens with a patient with BPD during a crisis and how a Brief Admission can help this patient recover.

Figure 1. Borderline personality disorder patients' interpersonal coherence and the role of Brief Admission (BA)



According to the theory of interpersonal vulnerability as developed by Gunderson and Links (see Figure 1), provision of a "holding" environment and a supportive attitude among nurses at the ward can help patients recover from crisis. Depending on the level of functioning or, stated differently, the level of crisis characterizing the patient at a given point in time, the patient's needs will differ. The needs of the patient may also differ depending on the course of their recovery and the amount of time already spent in therapy.

The SAMSHA report on BPD (2011) has also emphasized the importance of providing individualized treatment for patients with BPD. In the report, it is also stressed that patients will need different things at different times during the course of their recovery and that effective treatment takes this variability into account. The results of the case study reported on in this thesis clearly support this conclusion. The patient in our study was very clear about her lack of skills at the start of the use Brief Admissions when she stated that she could not ask for help directly. She reported feeling "threatened" and "aloneness" during a crisis. And she also reported the need for a nurse to actively support her during this stage of her treatment. Later in her treatment, she became more independent and developed the capacity to actively come into contact with a

nurse. She still felt “threatened” at times and particularly during a crisis, but recovered much quicker from these feelings following her extensive treatment. During this stage of treatment, the nurses indeed encouraged the patient to take responsibility for contacting them during a Brief Admission and thereby enhance her autonomy.

Brief Admission for the provision of a “holding” environment

As shown in figure 1, one of the helping components of a Brief Admission, is the holding environment. Our research showed admission to a mental health facility or what was often perceived to be a “holding” environment gave patients a clear sense of safety because the patient was not alone and a nurse was always present. This is especially important when a patient is experiencing symptoms like dissociation and suicidal thoughts as described in at “Aloneness” and “Despair”. The structure on the ward helps them to regain a healthy day/night rhythm. And many patients describe how they need a Brief Admission to get out of the home situation or a situation of conflict and thus a situation in which they lose control over their thoughts and feelings — a situation that they are not able to come out of this alone. The boundaries set for a Brief Admission — including no abuse of alcohol or drugs, no use of violence, and no self-harm — were also explicitly welcomed by patients as they provided clarity, helped them opt for healthy coping skills, and gave them a sense of support. Having created a Brief Admission plan in advance, knowing how long they can stay and knowing how often they can use a Brief Admission are also reported by patients as making them feel safe.

Active support and contact with a nurse

In some of the protocols analyzed for the use of Brief Admission, no nurse-patient interaction was stipulated — only the supply of a “hotel bed” for the patient. And yet the results of the other studies reported on here clearly show just how crucial contact with a nurse is for a patient in crisis. The results of the interview study showed patients to find it extremely difficult to return to feeling “connected” again without contact, without some connection, with a nurse. Gunderson and Links (2014) describe how nurses and other clinicians need to be active and not reactive in their support of a patient with a BPD and in crisis. This is particularly the case when the patient is not just feeling “threatened” but suffering from “aloneness” and thus inclined to *reject* the help of others.

In many of the protocols analyzed as part of the present research, it is nevertheless explicitly stated that the *patient* is responsible for initiating a conversation with the ward nurse. The reasoning behind this is that the patient can gain experience with being assertive and actively seeing help and contact in a relatively safe environment. The question, of course, is whether this occurs or not and whether the therapeutic goal of enhancing patient autonomy is somehow countered by active nurse involvement.

However, the results of the patient interviews conducted as part of the present research show nurses and other mental professionals to *overestimate* the ability of patients with a BPD and particularly those at the start of treatment for such a disorder to get into contact with a nurse and put thoughts and feelings into words. Patients are more often in the "aloneless phase" than nurses expect. Once patients have acquired sufficient self-confidence and self-coping skills as part of their treatment for a BPD, however, responsibility for contact with a nurse can gradually shift from the nurse to the patient. Just how the nurse should approach a patient with a BPD during a Brief Admission thus depends on the patient's level of interpersonal skill, the phase of treatment, and the patient's current psychological state (i.e., acute crisis or not). The mixture of interactional determinants can not only vary from patient to patient but also over time and within the same patient. It may thus be very helpful for nurses if, for each patient, the following elements are noted: the Brief Admission plan, the phase of treatment, the level of interpersonal skills, and just how the patient wants to be approached during a crisis.

METHODOLOGICAL CONSIDERATIONS

Some methodological issues should be considered to evaluate the quality and representativeness of our findings. The study on patient perspectives, the patient case study, and the expert Delphi study were all performed within the Dimence Mental Health Care Group. This organization is composed of four clinics that all deliver Brief Admission interventions but in different cities. The Brief Admission practices and policies of the four clinics showed major differences in admission procedures, attitudes toward patients, and ward culture. In our opinion, this variability enhances the generalizability of our results. Nevertheless, the fact that the results stem from a single overarching organization may limit the generalizability of our findings to mental health care in general and Dutch mental health care in particular.

It is also possible that sampling bias may have occurred in the qualitative study of patient perspectives, given that the vast majority of the participants was female. Men and women show similar prevalences of BPD: 5.6% among men, 6.2% among women (Grant et al., 2008). According to Sansone and Sansone (2011), however, gender differences may arise as a result of the sampling bias that manifests itself in psychiatric settings. That is, the traditional settings for prevalence studies (i.e., psychiatric settings) have been shown to not reflect the true gender distribution of BPD; women with BPD are more likely to be over-represented in mental health services (Goodman et al., 2010) while men with BPD are more likely to be over-represented in substance abuse treatment programs and/or prison. Men with BPD are similarly more inclined than women with BPD to have an explosive temperament and substance abuse problems coupled with high levels of novelty seeking and antisocial personality characteristics (Barnow et al., 2007; Zanarini et al., 1998). The underrepresentation of male patients

with BPD in the present study of patient perspectives thus means that we cannot be sure about the generalizability of the results to male patients with BPD.

No study of the effectiveness of Brief Admissions was conducted within the context of the present thesis. The goal of the present research was, rather, to gain clarity on what Brief Admission as a crisis intervention entails, which components appear to be most important, and what components of Brief Admission can help achieve the goals set by both patients with BPD and professionals. In other words, as described in the MRC framework for the development and evaluation of complex interventions (Craig et al., 2008), the present work can be characterized as “development” work in which the necessary evidence base and theory for a complex intervention are developed.

Strength of the thesis is that different sources of data were called upon and “inter-subjectivity” was attained by taking the perspectives of patients, professionals, different clinics, and relevant policy into consideration. In this perspective the occurrence of possible bias stemming from a single interpretation in this thesis is prevented.

MAIN CONCLUSIONS

Brief Admission is an effective self-management intervention available to prevent prolonged admission to a mental health facility, prevent drop-out from ongoing therapy, help patients with BPD to acquire and practice new skills, and promote the autonomy of patients with BPD. Patients point to the *quality of the contact with a nurse* during a Brief Admission as a critical component for a helpful admission. The further success of a Brief Admission depends on the development of an individualized Brief Admission plan developed in collaboration between the patient, a nurse, and community care professional but also embedded in the overall treatment plan. The allowable frequency and duration of a Brief Admission should be agreed upon and tailored to the needs of the patient, which can vary over time and from patient to patient. The same applies for other interventions to be used to help the patient with BPD and a crisis (or pending crisis) regain control over their emotions, thoughts, and problems. It is further crucial that the patient him/herself initiate the Brief Admission whenever possible in order to enhance self-management skills. There is further consensus that for a Brief Admission to be beneficial, prohibition of the use of alcohol or drugs, occurrence of aggressive behavior, and self-harming behavior must be clearly communicated.

FUTURE RESEARCH

The results of the present research can be drawn upon to take the next steps in the MRC framework for the development and evaluation of complex interventions (2008). The effectiveness of Brief Admission as a self-management crisis intervention for patients with BPD is currently being tested in a cluster randomized control trial (RCT)

in Sweden. To prepare for a RCT, according to the MRC framework for the development and evaluation of complex interventions (Craig et al., 2008), the feasibility of the proposed intervention should first be evaluated in a pilot study. This preparatory pilot study, prior to the RCT, in Sweden has been completed with success, and the results will soon be reported. For the pilot study, the following were developed: a Brief Admission protocol, a fidelity measure, and a one-day training for the relevant professionals. In addition, a scale for patients and professionals allowing them to rate their experience with Brief Admission was developed. The writer of this thesis is participating in the research group responsible for this research in Lund, Sweden.

Given the results reported on here and the study to be conducted in Sweden, we further recommend that a costs-effectiveness study of the use of Brief Admission for crisis intervention be conducted. This can perhaps be accompanied by a process evaluation study on the implementation and conduct of Brief Admission in different settings. The Brief Admission intervention must be tailored to specific organizational circumstances without the loss of key components as specified by the evaluation and implementation guidelines provided by the MRC framework.

RECOMMENDATIONS FOR MENTAL HEALTH PRACTICE

Mental health care organizations in the Netherlands committed themselves to reducing the numbers of beds needed for mental health care hospitalization by 33% before the year 2020 (Bestuurlijk akkoord geestelijke gezondheidszorg 2014-2017, 2013). In line with government policy, the focus of efforts to do this should be on the provision of more and better community mental health care, organized preferably in the neighborhoods of cities together with the availability of Brief admission as intervention to prevent escalation of a crisis or pending crisis (Delespaul et al., 2016). Yet as a side effect of reducing the number of hospital beds available for mental health care, there will also be a concomitant reduction in the number of beds available for Brief Admission. Indeed in the study by Van den Reek & De Muijnck, (2015), 20 patients reported having fewer and fewer possibilities for a Brief Admission. When in crisis, they asked for a Brief Admission but were told that no beds were available at the time. According to the self-reports of patients, the unavailability of a place for a Brief Admission can have very serious consequences for them and lead to self-harm, attempted suicide, longer admission, and even involvement of the police when the family cannot handle the patient resulting in the jailing of the patient for acts of aggression or threats of aggression.

In light of unwelcome side-effect mentioned above, we thus recommend that Brief Admission beds be kept available in mental health care facilities. The organization of Brief Admission interventions as part of a structured treatment for patients with BPD in the community care must thus be done together with a clinic offering the required space. Although this has yet to be tested for effectiveness, there is a high level of

consensus that Brief Admission interventions should be incorporated into the Care Programs and Clinical Pathways for BPD in Mental Health Care.

Furthermore, the consensus-based components of Brief Admission found to be most important in this thesis should be added to the already existing Brief Admission protocols and practices for at least patients with BPD. Also based on the results of the studies reported here, we drafted a protocol for the delivery of Brief Admission (Appendix 1). We would further like to challenge mental health care organizations in the Netherlands to compare their Brief Admission protocols to the newly drafted Brief Admission protocol provided here.

Recommendations for nursing education

Education on the use of Brief Admission interventions for crisis intervention and the promotion of self-management should be given to mental health professionals. This should include basic knowledge of the symptoms of BPD, the important components of a Brief Admission, and the use of Brief Admission in conjunction with BPD.

Recommendations for delivery of Brief Admission

It is highly recommended that the development of Brief Admission agreement with a patient include three parties: the patient, a clinician from the mental health facility offering the Brief Admission, and the community mental health care professional. When these three parties cooperate on the development of the Brief Admission plan, there will be clarity on the frequency and duration of the Brief Admission right from the start, which can prevent unnecessary struggles for the attainment of a Brief Admission and a patient's self-management.

Quality contact with a nurse during a Brief Admission was reported to be the most important component of a successful Brief Admission by patients with a BPD. For a Brief Admission to help a patient recover from a crisis (or pending crisis), the possibility of contact with a nurse during the Brief Admission must be present. Nurses should be made aware of the importance of connecting with such patients during their Brief Admission, particularly in light of the interpersonal hypersensitivity that characterizes patients with BPD.

Finally, it is recommended to deliver the Brief Admission on an open ward, to enhance the possibilities of patients to grow in autonomy.

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7

Summary

In this thesis, research for the development of the Brief Admission as a self-management crisis intervention for patients with borderline personality disorder (BPD) was undertaken. Existing evidence was identified via the conduct of a systematic review of the literature. Thereafter, specific studies were undertaken to clarify the design of Brief Admission as a crisis intervention and to identify the most relevant components.

Chapter 1 describes the General Introduction. Patients with BPD will experience crises due to their symptoms, but disruptions of outpatient treatment by lengthy admissions should be avoided whenever possible because of 1) the negative side effects and 2) the need to develop patient autonomy and sufficient insight to deal with crisis or possibly prevent it. In the Netherlands, Brief Admissions were initially adopted to deal with the vulnerability of patients with BPD and to avoid lengthy admissions. Brief Admission used for crisis intervention can be considered a complex intervention, with several interaction components, as described by the MRC framework (2008). Despite of the fact that Brief Admissions have been used for decades, very little is known about the working elements of Brief Admissions, just how Brief Admission works, or what outcomes can be expected when Brief Admission is put to use. This implies that, in relation to the MRC framework, exploratory work is still needed to guide the development of the intervention and provide a framework for understanding the utility of Brief Admission for crisis intervention and prevention.

The first research objective was: "*To identify the key components of Brief Admission as a crisis intervention for patients with a BPD as well as the evidence base for these components of Brief Admission*". In **Chapter 2,** the conduct and results of the literature review on this topic are described. Articles in all languages were considered and included for initial consideration, provided a discussion of BPD and Brief Admission was clearly apparent (i.e., Brief Admission interventions or components of Brief Admission as an intervention were discussed). Quantitative studies, qualitative studies, reviews, and practice reports were included. In the end, 10 articles met the inclusion criteria for the review: 5 quantitative studies, 1 mixed-methods study, and 4 qualitative studies. No relevant randomized controlled trials were found. Content analyses were then conducted on the components of the interventions described in the studies included in the review.

The literature showed five key components:

1) *Discussion of Goals.*
The most important goal was prevention of prolonged psychiatric hospitalization and providing a hospital setting that does not gratify dependency needs. Also, facilitating ambulatory treatment through limitation of crisis hospitalizations and to lower rates of treatment disruption was a clear goal. Reduction of repeated self-harm and suicidal crisis along with the prevention of death was an obvious goal, as well preventing power struggles between patient and professional about the amount of care to be offered. Finally, a quick return to the community and facilitating rather than distancing community contact were mentioned, in relation to relieving pressure on specialized inpatient services.
2) *Organization of a Brief Admission.*
The literature mentioned how patients discussed and agreed upon the conditions for Brief Admission with the clinician in advance of times of crisis and how they agreed on the frequency and duration of Brief Admission, and use of Brief Admission in relation to their crisis plans.
3) *Admission Procedure.*
The review of the included manuscripts revealed that admission to the hospital was initiated by the patient. Some manuscripts described how patients directly called the hospital to request for a Brief Admission, without the intervention of a clinician. Responsibility for the use of a Brief Admission intervention was thus placed in the hands of the patient. However, some authors also reported how decisions regarding Brief Admission were made in consultation with the patients' case manager or another healthcare professional.
4) *Interventions Used During a Brief Admission.*
In five of the studies, the Brief Admission was a stay in the hospital, which offered the possibility of a conversation with a nurse. Other studies describe an active, rapid response to the psychiatric, psychological, interpersonal, financial, and/or housing factors contributing to the need for admission. Both individual and family sessions for crisis management and problem solving were held for this purpose. In 2 of the 10 studies, medication was prescribed as necessary.
5) *Conditions for Premature Discharge.*
The term "premature discharge" refers to a forced discharge due to violation of agreements on the ward for Brief Admission. Violation of the treatment contract could be a condition for premature discharge. In other cases, discharge could follow self-harming behavior, aggressive behavior, or alcohol/drug use.

The focus in **Chapter 3** is on the experiences of patients suffering from a BPD with the use of a Brief Admission for crisis management. This in order to answer the second research objective, which was "*To describe BPD patients' experiences with Brief Admissions*". An interview study using the descriptive phenomenological methodology of Giorgi (2008) was conducted for this purpose. The inclusion criteria for patients in this phenomenological study were: a diagnosis of BPD according to the Diagnostic and Statistical Manual of Mental Disorders–IV criteria; experience with Brief Admission; and sufficient understanding of the Dutch language. A total of 16 female patients and 1 male patient participated in the study. A qualitative, in-depth interview was conducted with each of the 17 participants. Four essential components of a Brief Admission from the perspective of patients making use of Brief Admissions could be identified:

- *Organization of the Brief Admission,* including: the Brief Admission treatment plan, the specific goals of the Brief Admission, the admission procedure, and having a conversation with a nurse at the start of the Brief Admission.
- *Contact with a nurse*. This component was described by patients as the most important component of a Brief Admission. Nurse contact was reported to help them reconnect with themselves. Via contact with a nurse, patients reported feeling heard, seen, and accepted; they reported feeling comfortable enough to share their vulnerabilities with the nurse.
- *Time out from daily life*. Many patients highly valued being able to take a step back from their daily lives during a Brief Admission. This allowed them to get some rest; gave them structure; provided them with distraction; and allowed them to meet and interact with fellow patients.
- *Experienced value for the patient;* Relaxation and prevention of a total loss of control were perceived as positive aspects of the use of Brief Admissions. As patients became more experienced with their use they reported becoming more autonomous and taking greater responsibility for their recovery. The availability of a Brief Admission in time of crisis was also reported as giving give the patient a sense of security.

Research objective three was "*To understand the Brief Admission's potential contribution to the treatment process*". **Chapter 4** gives insight in the use of Brief Admissions to a psychiatric ward by a single patient across a period of seven years by using a single-case descriptive design. The patient suffered from a Borderline Personality Disorder and a Complex Post Traumatic Stress Disorder (PTSD). Semi-structured interviews were conducted with the patient the patient's spouse, psychiatrist, ward nurse and community psychiatric nurse. Other data was retrieved from the medical records of the patient. Four phases could be distinguished in the treatment of the patient: crisis, treatment of PTSD, treatment of BPD and recovery. The use of Brief Admissions positively influenced the course of treatment. Brief

admissions were initially used to prevent self-harm and suicide. The goals and functions expanded to prevention of prolonged admission, prevention of drop-out from evidence-based therapy, and practicing with newly acquired skills and promotion of autonomy.

In **Chapter 5** the fourth research objective is reported on: "*To describe the similarities and differences found to date in the protocols provided by organizations using Brief Admission as an intervention for patients with borderline personality disorder*". The results of a descriptive study of the organization of Brief Admissions in the Netherlands are presented. The similarities and differences in the protocols provided by organizations using Brief Admission as an intervention for patients with BPD were examined for this purpose. The content of 41 protocols for the use of Brief Admission as an intervention at 33 mental health care facilities was analyzed. The initial content analysis was conducted using a list of 22 items identified on the basis of the previous two studies (i.e., the review and interview study

The study shows that in 34 of the 41 protocols analyzed, a Brief Admission treatment plan was developed with the patient prior to the occurrence of a crisis and included in the patient's overall treatment plan. The maximum frequency of Brief Admission allowed by the institution ranged from 4 times a month (n=6) to once a month (n=1), or to an individually determined frequency tailored to the patient's specific needs (n=16). In more than half of the 41 analyzed protocols, it is stated that the patient can call the ward directly when in crisis to request a Brief Admission (n=23).

The central goals mentioned in most of the Brief Admission protocols were: to prevent crisis and the need for long-term admission; prevent deliberate self-injury or suicidal acts; to restore day/night structure and self-care; and to prevent drop-out from outpatient psychotherapeutic treatment.

In 22 protocols, the patients had a crisis plan which included Brief Admission intervention as an option to prevent escalation. Half of the protocols included a clear policy on such behaviors as self-injurious acts (n=20), aggressive acts (n= 21), use of alcohol or drugs (n= 20), or attempted suicide (n= 18) during the Brief Admission. In these protocols it is stated that such occurrences are prohibited and the behavior will result in discharge.

The interventions are outlined as part of the individual patient's crisis plan and thus tailored to the needs of the patient. These include taking breaks, getting enough rest, and undertaking relaxing/distracting activities like walking, drawing, listening to music, or calling a friend. When the patient is well known to the clinic, the intake interview can be conducted by a nurse from the clinic without a psychiatrist present.

In **Chapter 6** the last research objective is answered: "*To obtain consensus of professionals on the relevance of the components of the intervention Brief Admission as a crisis intervention for patients with a borderline personality disorder*". The study

described in this chapter was conducted during a four-month period in 2015 and included 88 Dutch experts. In the end, 41 of the experts completed the entire Delphi procedure: 6 doctors, 24 clinical nurses, and 10 mental-health nurse practitioners and/or mental-health nurse researchers. The participants were asked to rate the relevance of 90 potential components of Brief Admission for the management of a crisis involving a patient with a BPD. Consensus of at least 70% agreement among the experts on the relevant components of a Brief Admission for crisis management was aimed for in two Delphi rounds. Consensus was reached for 82 of the 90 components derived from the previous studies. The highest consensus levels (100%) were reached for the following components of a Brief Admission:

- A Brief Admission plan must be developed *together* with the patient.
- Brief admission intervention should be mentioned in the patient's general care plan.
- Not all behavior on the part of the patient must be accepted or tolerated during a Brief Admission.
- The Brief Admission should only be offered in conjunction with treatment by a community care professional.

A number of other components also showed high consensus (≥ 70%).

- Patient must be able to commit to ward rules.
- Before patient can make use of a Brief Admission, a Brief Admission plan must be developed.
- Brief admission has to be explicitly stated as an option in the crisis plan for the patient.
- Aim of the Brief Admission should be to help the patient regain control over feelings, thoughts, and problems.
- Specification of clear boundaries with regard to alcohol and drug use, aggressive behavior, self-harming behavior, and suicide attempts during Brief Admission is important.
- Patients should try to attend outpatient therapy appointments they may have whenever possible during a Brief Admission.
- Patients should try to maintain their daily activities — like volunteer work — whenever possible during a Brief Admission.

Finally, in **Chapter 7** the main findings of the studies conducted to gain insight into the use, content and potential value of Brief Admission for purposes of crisis management are summarized and discussed. Methodological issues are considered to evaluate the quality and representativeness of the findings. Suggestions for further research and actual practice are made. Here, it is concluded that Gunderson and Links's (2014) theory regarding the manifestation of BPD may shed some light on the occurrence of difficulties with the use of Brief Admission for crisis management and particularly the

difficulties characteristic of the contact of patients with a BPD with nurses and other patients.

Conclusions

Brief Admission is a potentially effective self-management intervention available to prevent prolonged admission to a mental health facility, prevent drop-out from ongoing therapy, help patients with BPD to acquire and practice new skills, and promote the autonomy of patients with BPD. Patients point to the *quality of the contact with a nurse* during a Brief Admission as a critical component for a helpful admission. The further value of a Brief Admission depends on the development of an individualized Brief Admission plan developed in a collaboration between the patient, a nurse, and community care professional, yet also embedded in the overall treatment plan. The allowable frequency and duration of a Brief Admission should be agreed upon and tailored to the needs of the patient, which can vary over time and from patient to patient. The same applies for other interventions to be used to help the patient with BPD in crisis (or pending crisis) regain control over their emotions, thoughts, and problems. It is further crucial that the patient initiates the Brief Admission whenever possible in order to enhance self-management skills. There is further consensus that for a Brief Admission to be beneficial, prohibition of the use of alcohol or drugs, occurrence of aggressive behavior, and self-harming behavior must be clearly communicated.

Recommendations for mental health practice

We recommend that Brief Admission beds be kept available in mental health care facilities. The organization of Brief Admission interventions as part of a structured treatment for patients with BPD in the community care must thus be done together with a clinic offering the required space. Although this has yet to be tested for effectiveness, there is a high level of consensus that Brief Admission interventions should be incorporated into the Care Programs and Clinical Pathways for BPD in Mental Health Care.

Recommendations for nursing education

Education on the use of Brief Admission interventions for crisis intervention and the promotion of self-management of patients with BPD should be given to mental health professionals. This should include basic knowledge of the symptoms of BPD, the important components of a Brief Admission, and the use of Brief Admission in conjunction with BPD.

Recommendations for delivery of Brief Admission

It is highly recommended that the development of Brief Admission agreement with a patient include three parties: the patient, a clinician from the mental health facility offering the Brief Admission, and the community mental health care professional. When these three parties cooperate on the development of the Brief Admission plan, there will be clarity on the frequency and duration of the Brief Admission right from the start, which can prevent unnecessary struggles for the attainment of a Brief Admission.

For a Brief Admission to help a patient recover from a crisis (or pending crisis), the possibility of contact with a nurse during the Brief Admission must be present. Nurses should be made aware of the importance of connecting with patients during their Brief Admission, particularly in light of the interpersonal hypersensitivity that characterizes patients with BPD.

Finally, it is recommended to deliver the Brief Admission on an open ward, to enhance the possibilities for patients to grow in their autonomy.

Samenvatting

De studies in dit proefschrift hebben als doel om de Bed op Recept (BOR) als zelf management crisisinterventie voor patiënten met een borderline persoonlijkheidsstoornis (BPD) systematisch te ontwikkelen.

Hoofdstuk 1 beschrijft de Inleiding. Patiënten met BPD maken crises door, ten gevolge van de symptomen van BPD. Lange opnames in de psychiatrie kunnen beter voorkomen worden, vanwege het risico op regressie en omdat het belangrijk is om de autonomie en verantwoordelijkheid niet over te nemen van de patiënt, zodat deze kan leren om zelf zijn crises te hanteren. In Nederland is de BOR ontstaan om lange opnames te voorkomen maar de patiënt wel een mogelijkheid te bieden voor een korte opname tijdens kwetsbare periodes. Door het inzetten van de BOR wordt tevens getracht destructief gedrag, zoals zelfbeschadiging of suïcidepogingen, te voorkomen.
De BOR heeft echter geen gedegen evidence-base en wordt heel verschillend toegepast. Waarom we de BOR inzetten is duidelijk, maar wat we dan precies tijdens een BOR doen, of moeten doen is niet duidelijk. De BOR is een complexe interventie en heeft verschillende componenten, zoals het opstellen van het BOR plan, de korte opname op een afdeling, de communicatie over en weer tussen de verpleegkundige en de patiënt, het afstemmen van de acties van de verpleegkundige op de conditie van de patiënt, enz. Er is onderzoek nodig om de werking van de BOR als zelfmanagement crisisinterventie voor patiënten met BPD te verduidelijken.

De eerste onderzoeksvraag was: “Wat zijn de componenten van de BOR als een crisisinterventie voor patiënten met BPD; en wat is de evidence base voor deze componenten?”. In **hoofdstuk 2**, worden de uitvoering en de resultaten van een literatuur onderzoek beschreven. Artikelen kwamen in aanmerking voor inclusie als de BOR voor patiënten met BPD erin beschreven werd. Zowel kwantitatieve studies, als kwalitatieve studies en reviews werden geïncludeerd. Uiteindelijk zijn 10 artikelen geïncludeerd voor de review: 5 kwantitatieve studies, 1 mixed-methods studie en 4 kwalitatieve studies. De componenten van de BOR in de artikelen zijn geanalyseerd door middel van content analyse.

De vijf belangrijkste componenten van de BOR, volgens de studies, zijn:
1. *Bespreken van het doel van de BOR*
Het belangrijkste doel van de BOR is om lange opnames te voorkomen en om een cultuur op de afdeling te bewerkstelligen die regressie en afhankelijkheid van patiënten tegengaat. Ook wordt de ambulante behandeling ondersteund doordat de behandeling zo min mogelijk wordt onderbroken door (lange) crisisopnames. Het voorkomen en verminderen van zelfbeschadiging en suïcidaliteit wordt als doel beschreven, net als het voorkomen van conflicten tussen patiënten en professionals

over de hoeveelheid zorg die nodig wordt geacht. Ook een snelle terugkeer naar het dagelijks leven en daarbij het herstellen van contacten is een doel van de BOR.

2. *Organisatie van de BOR*

Patiënten maken afspraken over het gebruik van de BOR met hun ambulante behandelaar voordat zij met de BOR starten. Er wordt overeenstemming bereikt over het aantal BOR opnames, de duur van de BOR en waar de BOR een plek krijgt in het signaleringsplan of crisisplan van de patiënt.

3. Opname procedure.

In de meeste gevallen is beschreven dat de patiënt het initiatief neemt voor een BOR opname. De patiënt belt zelf met de afdeling met een verzoek voor een BOR. De verantwoordelijkheid voor het gebruik van de BOR ligt dan in handen van de patiënt. In andere gevallen overlegt de patiënt eerst met zijn ambulante behandelaar of er een indicatie voor een BOR is.

4. *Interventies tijdens een BOR*

In vijf van de studies wordt tijdens een BOR de mogelijkheid geboden voor een gesprek met een verpleegkundige. Andere studies beschrijven een actieve, snelle respons op de psychiatrische, interpersoonlijke, financiële en/of huisvestingsproblemen die de crisis bij de patiënt veroorzaakt hebben en een BOR noodzakelijke maken. Zowel individuele als familie sessies voor crisismanagement worden aangeboden. In 2 van de 10 studies is medicatie voorgeschreven indien dit nodig is.

5. *Gedwongen voortijdig ontslag van een BOR*

Met voortijdig ontslag wordt bedoeld dat de patiënt eerder dan is afgesproken met ontslag gaat omdat (afdelings)regels betreffende de BOR zijn overtreden. Ook als de afspraken die in het BOR plan staan niet worden nageleefd kan ontslag volgen. Bijvoorbeeld na agressief gedrag, middelenmisbruik of zelfbeschadiging.

De focus in **hoofdstuk 3** is op de ervaringen van patiënten met BPD met het gebruik van de BOR als zelfmanagement interventie bij crisis. De onderzoeksvraag van deze studie was: ”Wat zijn de ervaringen van patiënten met BPS met de BOR?”. Er is een beschrijvend fenomenologisch design gebruikt volgens de methodologie van Giorgi (2008). De inclusie criteria waren: diagnose van BPD volgens de DSM-IV criteria; ervaring met de BOR en begrip hebben van de Nederlandse taal. 16 vrouwen en 1 man participeerden in deze studie. Hiermee zijn kwalitatieve, diepgaande interviews gevoerd. Data saturatie werd behaald op het moment dat geen nieuwe informatie naar boven kwam (na 15 interviews).

Er zijn vier hoofd componenten van de BOR geïdentificeerd vanuit het perspectief van de patiënten.

- *Organisatie van de BOR.* Met daarin het BOR plan, de specifieke doelen van de BOR, de opnameprocedure van de BOR en het startgesprek met de verpleegkundige bij het begin van de BOR.

- *Contact met de verpleegkundige.* Patiënten beschreven dit als het belangrijkste component van een BOR. Het contact met de verpleegkundige helpt hen om contact te kunnen maken met hun eigen emoties. Het contact met de verpleegkundige maakt dat de patiënt zich gezien, gehoord en geaccepteerd voelt, waardoor er genoeg veiligheid in contact ervaren wordt om kwetsbare onderwerpen te delen met de verpleegkundige.
- *Time-out van het dagelijkse leven.* Patiënten vinden het erg waardevol dat zij een time-out kunnen nemen van hun dagelijkse leven tijdens een BOR. Dit geeft de mogelijkheid om uit te rusten en te ontspannen. De BOR geeft structuur, afleiding en de mogelijkheid om contacten te hebben met medepatiënten.
- *Ervaren waarde van de BOR.* Ontspanning en het tegengaan van een totaal verlies van controle worden genoemd als de positieve aspecten van het gebruik van een BOR. Als patiënten meer ervaring met de BOR opdoen geven ze aan dat ze autonomer en zelfstandiger worden en meer verantwoordelijkheid tijdens de BOR kunnen nemen voor hun herstel. De beschikbaarheid van de BOR in tijden van crisis geeft de patiënten een veilig gevoel.

De derde onderzoeksvraag is: “Wat is de bijdrage van de BOR aan een langdurig behandeltraject?” **Hoofdstuk 4** beschrijft het gebruik van de BOR door één patiënt gedurende een periode van 7 jaar. Een single-case beschrijvend design is gebruikt. De patiënt was gediagnosticeerd met BPD en complexe PTSS. Semi-gestructureerde interviews zijn afgenomen bij de patiënt, diens echtgenoot, psychiater, afdelingsverpleegkundige en sociaal psychiatrisch verpleegkundige. Overige data was verzameld vanuit het dossier van de patiënt. Vier fases konden onderscheiden worden gedurende de behandeling van de patiënt: “crisis”; “behandeling van PTSS”; “behandeling van BPD” en “herstel”. Het gebruik van de BOR heeft een positieve invloed gehad op het verloop van de behandeling. De BOR werd ingezet om zelfbeschadiging of suïcide te voorkomen. De doelen van de BOR veranderden gedurende het verloop van de behandeling en breidden zich uit, van “voorkomen van (lange) opname”; “voorkomen van drop-out uit behandeling”; “oefenen met geleerde vaardigheden”; tot “vergroten van autonomie”.

In **hoofdstuk 5** wordt antwoord gegeven op de onderzoeksvraag: “*Beschrijf de overeenkomsten en verschillen tussen BOR protocollen van afdelingen voor psychiatrische opname in Nederland*”. De inhoud van 41 protocollen van 41 afdelingen voor het gebruik van de BOR, in 33 instellingen voor geestelijke gezondheidszorg zijn geanalyseerd. Content analyse is uitgevoerd met behulp van een lijst met 22 items die is opgesteld op basis van de eerdere studies naar de BOR. De uitkomsten laten zien dat in 34 van de 41 protocollen een BOR plan wordt opgesteld met de patiënt voordat

daadwerkelijk met de BOR gestart wordt. Dit BOR plan is toegevoegd aan het behandelplan van de patiënt.
De maximale frequentie van een BOR per maand varieerde van 1 tot 4 keer per maand. Ook werd deze individueel bepaald op basis van de zorgvraag van de patiënt. In meer dan de helft van de protocollen kan de patiënt direct met de afdeling bellen om om een BOR te vragen. De doelen voor de BOR die genoemd zijn in de BOR protocollen zijn: voorkomen van crisis en lange opnames; voorkomen van zelfbeschadiging of suïcide pogingen; herstellen van dag/nacht structuur en adequate zelfzorg en het voorkomen van drop-out uit de ambulante psychotherapie.
In 22 protocollen staat dat de BOR genoemd is als optie om escalatie te voorkomen, in het crisis- of signaleringsplan van de patiënt. De helft van de protocollen beschrijft dat het beleid is dat ontslag volgt als er sprake is van zelfbeschadiging, agressie, middelenmisbruik of suïcidepogingen tijdens een BOR. In het BOR plan worden specifieke interventies beschreven die worden afgestemd op de individuele zorgbehoefte van de patiënt. Het gaat meestal om ontspannende en afleidende activiteiten die bij deze specifieke patiënt kunnen helpen om zelf beschadiging te voorkomen.

In **hoofdstuk 6** is de laatste onderzoeksvraag beantwoord: “Over welke componenten van de BOR als crisis interventie voor patiënten met BPD bestaat consensus over de relevantie onder professionals?”.
De Delphi studie is uitgevoerd gedurende 4 maanden in 2015 en 88 Nederlandse experts zijn geïncludeerd. Uiteindelijk hebben 41 experts de hele Delphi procedure afgerond: 6 psychiaters, 24 afdeling verpleegkundigen, 10 verpleegkundig specialisten GGZ en/of verpleegkundig wetenschappers. De experts zijn gevraagd om de relevantie van 90 componenten van de BOR aan te geven op een 5 punten schaal. Als er 70% overeenstemming was over de relevantie van een component van de BOR onder de experts werd dit als consensus beschouwd. Er waren twee Delphi rondes. Voor 82 van de 90 componenten is consensus bereikt. 100% overeenstemming is bereikt voor de volgende componenten van de BOR:

- Een BOR plan moet samen met de patiënt opgesteld worden.
- De BOR moet genoemd worden in het behandelplan van de patiënt.
- Niet al het gedrag van de patiënt hoeft geaccepteerd of getolereerd te worden tijdens een BOR.
- De BOR moet alleen aangeboden worden in combinatie met een ambulante behandeling.

De volgende componenten hadden een hoge consensus

- De patiënt moet in staat zijn om zich aan de afdelingsregels te houden.

- Voor een patiënt gebruik kan maken van de BOR, moet een BOR plan opgesteld worden.
- De BOR moet als een optie genoemd staan in het crisis- of signaleringsplan van de patiënt.
- Het doel van de BOR zou moeten zijn om de patiënt te helpen om weer controle te krijgen over zijn emoties, gedachten en problemen.
- Het is belangrijk om duidelijke grenzen te stellen met betrekking tot middelen misbruik, agressief gedrag, zelfbeschadiging en suïcide pogingen tijdens de BOR.
- Patiënten moeten proberen de ambulante afspraken voor therapie zoveel mogelijk te blijven volgen tijdens een BOR.
- Als het mogelijk is zouden patiënten moeten proberen om hun dagelijkse activiteiten, zoals vrijwilligerswerk, te blijven doen tijdens een BOR.

Als laatste worden in **hoofdstuk 7** de belangrijkste uitkomsten van de studies op een rij gezet en bediscussieerd. Methodologische aspecten zoals de generaliseerbaarheid van de studies worden besproken, net als suggesties voor verder onderzoek.
De theorie over de manifestatie van BPD van Gunderson en Links's verklaart waarom het contact met patiënten met BPD in een crisis, tijdens de BOR, soms ingewikkeld kan zijn voor verpleegkundigen. De theorie verduidelijkt ook welke attitude en interventies tijdens de BOR het beste ingezet kunnen worden.

Conclusies
De BOR is een effectieve zelfmanagement interventie om lange opnames in de psychiatrie te voorkomen, om drop-out uit therapie te voorkomen, om patiënten met BPD te helpen zich nieuwe vaardigheden eigen te maken en deze te oefenen en om de autonomie van patiënten met BPD te vergroten. Patiënten stellen dat de kwaliteit van het contact met de verpleegkundige tijdens de BOR de kritische component is voor een effectieve BOR. Het verdere succes van de BOR hangt af van een geïndividualiseerd BOR plan, opgesteld in samenwerking met de patiënt, een verpleegkundige van de kliniek en de ambulant behandelaar. Dit BOR plan moet in het behandelplan worden geïntegreerd. Er is overeenstemming nodig over het aantal en de duur van de BOR per maand. Dit moet afgestemd worden op de zorgbehoefte van de patiënt, welke kan veranderen gedurende de tijd. Hetzelfde geldt voor ander interventies die tijdens de BOR worden ingezet om de patiënt met BPD in crisis te helpen weer controle te krijgen over emoties, gedachten en problemen.
Het is verder belangrijk dat de patiënt zelf het initiatief kan nemen om om een BOR te vragen wanneer dit nodig is, om zo zelfmanagement vaardigheden te vergroten. Er is consensus dat duidelijke grenzen op het gebied van middelenmisbruik, agressief gedrag

of zelfbeschadiging belangrijk zijn bij een BOR, deze voorwaarden staan in het BOR plan van de patiënt.

Aanbevelingen voor de praktijk

Wij adviseren om BOR bedden beschikbaar te houden in GGZ instellingen. De organisatie van de BOR zou idealiter onderdeel moeten zijn van een gestructureerde behandeling voor patiënten met BPD in ambulante behandelteams, samen met de kliniek die de BOR bedden levert. Er is een hoog niveau van consensus onder professionals dat de BOR opgenomen zou moeten worden in de zorgprogramma's en zorgpaden voor de behandeling van BPD in de GGZ. De effectiviteit hiervan moet nog onderzocht worden.

Aanbevelingen voor de verpleegkundige praktijk

Wij bevelen aan de afdelingsverpleegkundigen en ambulant behandelaren te scholen in de BOR als zelfmanagement crisisinterventie. De inhoud van de scholing zou basiskennis over BPD behandelen, de belangrijkste componenten van de BOR bespreken en vooral ook de benodigde attitude van de verpleegkundige, die de ene keer steunend zal zijn en de andere keer meer gericht op het stimuleren van de eigen verantwoordelijkheid van de patiënt.

Aanbevelingen voor de afdelingen waar de BOR wordt aangeboden

Het is sterk aan te bevelen om het BOR plan uit te werken met drie partijen: de patiënt, een verpleegkundige van de afdeling waar de BOR plaatsvindt en de ambulante behandelaar. Als deze drie partijen samenwerken om het BOR plan op te stellen, zal er vanaf de start volkomen duidelijkheid zijn over het aantal en de duur van de BOR. Dit kan discussies en onduidelijkheid over ontslagdata tijdens de BOR voorkomen.

Contact met de verpleegkundige tijdens de BOR

Patiënten geven aan dat het contact met de verpleegkundige tijdens de BOR de belangrijkste voorwaarde is voor een succesvolle BOR. Zonder dit contact is het erg moeilijk voor patiënten om uit de negatieve gedachtencirkels te komen, hun emoties te hanteren en spanning te verlagen, en dus te herstellen van hun crisis. Verpleegkundigen zouden zich bewust moeten zijn van het grote belang om heel bewust contact te zoeken met patiënten met BPD in crisis helemaal gezien de interpersoonlijke gevoeligheid en angst die BPD karakteriseren. Als een patiënt zich gehoord, gezien en geaccepteerd voelt, is er veiligheid in het contact om gevoelens en gedachten te delen.

Tenslotte is het aan te bevelen om de BOR aan te bieden vanaf een open afdeling, om zo de mogelijkheden voor de patiënt om te groeien in autonomie te versterken.

Protocol Bed op recept (BOR)

Dit BOR protocol kan gebruikt worden door afdelingen en klinieken om hun eigen BOR protocol te beschrijven.

Onderwerp: Wat is een Bed op recept?

Een Bed op recept (BOR) wordt ingezet als een zelfmanagement interventie voor patienten met een (borderline) persoonlijkheidsstoornis om crisis te voorkomen of verminderen. De BOR is een ultra korte opname die binnen een klinische setting, op een open afdeling geboden wordt.

De BOR is een korte opname in een psychiatrische opname afdeling van een PAAZ, academisch ziekenhuis of een psychiatrisch ziekenhuis van 1 tot 3 nachten. Een BOR vereist een BOR plan welke is opgesteld met de patient, verpleegkundige van de kliniek en ambulante behandelaar voordat van een BOR gebruik kan worden gemaakt. Het BOR plan wordt opgesteld als de patient niet in crisis is. Tijdens het opstellen van het BOR plan wordt met de patient onderhandeld over het maximum aantal van BOR'ren per maand of drie maanden. Door dit tijdens de voorbereiding uit te onderhandelen, is er duidelijkheid over de mogelijkheden en worden power struggles tijdens de BOR voorkomen. De zelfredzaamheid en autonomie van de patient worden gestimuleerd en versterkt door het gebruik van de BOR, doordat de patient zijn BOR opnames zelf inzet, naar eigen inzicht. De patient leert steeds eerder een dreigende crisis te herkennen, hier verantwoordelijkheid in te nemen en actief om hulp te vragen.

Patienten in behandeling bij een ambulant behandelteam, met een BOR regeling, kunnen zelf om een BOR vragen zonder een opnamegesprek met een psychiater van de afdeling. De afdeling levert alleen verpleegkundige begeleiding tijdens de BOR. Een BOR kan alleen als zelfmanagement interventie gebruikt worden als de patient in staat wordt gesteld om *zelf* naar de kliniek te bellen, 24 uur per dag, om om een BOR te vragen (van den Reek & de Muijnck, 2015). Ook is een BOR opname op een open afdeling aanbevolen, om de mogelijkheiden voor patienten om te groeien in autonomie te vergroten. De BOR opname is een onderdeel van de BOR interventie. De BOR is niet bedoeld voor diagnostiek of het instellen op medicatie.

Doel van de BOR

- Voorkomen van destructief gedrag, zoals zelfbeschadiging, en suïcide
- Voorkomen van lange, ongerichte opnames op een niet-gespecialiseerde afdeling voor persoonlijkheidsstoornissen.
- Respecteren en versterken van de autonomie van de patiënt
- Voorkomen van drop-out uit de (ambulante) behandeling
- Ontwikkelen van en oefenen met coping vaardigheden.
- Bieden van een gestructureerde en veilige omgeving om te oefenen met interpersoonlijke, sociale en emotie regulatie vaardigheden.

Indicatie

- Patienten met (borderline) persoonlijkheidsstoornis.
- Patienten die in behandeling zijn bij een ambulant behandelteam.
- Patienten met een uitgewerkt BOR plan en BOR regeling bij de kliniek.

Contra-indicatie voor een BOR opname:

- Patiënten onder invloed van alcohol of drugs op het moment van BOR opname.
- Als een patient al in crisis is. Dit is een relatieve contra-indicatie.
- Sterk ontregeld gedrag, zich niet aan afspraken kunnen houden tijdens de BOR.

Werkwijze:

Voorbereiding van de BOR

Verantwoordelijkheden van de (regie) behandelaar van het ambulante behandelteam.

- De regiebehandelaar van het ambulante behandelteam is verantwoordelijk voor het behandelplan van de patiënt, het crisis- of signaleringsplan en het BOR plan. De BOR staat vermeld in het behandelplan en het crisis- of signaleringsplan van de patiënt.
- Het opstellen van het BOR plan zal in de regel door een behandelaar (SPV) worden gedaan.
- De verantwoordelijkheid voor het voorschrijven of wijzigen van medicatie blijft bij de psychiater van het ambulante team.
- Als er een indicatie is voor de BOR wordt de patiënt geïnformeerd over de BOR door zijn (regie) behandelaar. Deze maakt vervolgens een afspraak in de kliniek voor een driegesprek tussen de patiënt, verpleegkundige kliniek en ambulant behandelaar om het BOR plan op te stellen.

Opstellen van het BOR plan:

- De patiënt, verpleegkundige van de afdelingen en de ambulant (regie) behandelaar (in de regel een SPV) komen samen om een BOR plan op te stellen

- Het doel van de BOR wordt geformuleerd (preventie van crisis en destructief gedrag).
- Duur van de BOR wordt vastgesteld, hoeveel nachten?
- Aantal BOR'en per maand of drie maanden worden vastgesteld.
- In het BOR plan wordt beschreven wat de patiënt helpt om te ontspannen?
- In het BOR plan wordt beschreven dat de patiënt haar eigen medicatie meebrengt, bij voorkeur in een medicijn box.
- Praktische punten worden besproken, adres, telefoonnummer afdeling.
- In het BOR plan wordt beschreven dat de patiënt zelf direct met de afdeling kan bellen om te overleggen over een BOR, eventueel binnen bepaalde tijden.
- Er worden afspraken gemaakt over (vrijwilligers) werk, ambulante therapie, andere verantwoordelijkheden van de patiënt. Ambulante afspraken gaan zoveel mogelijk door.
- Patiënten worden geïnformeerd over de afdelingsregels. Eventueel worden aanvullende afspraken gemaakt.
- Aanpassing in behandelbeleid, inclusief medicatie, vindt plaats in overleg en onder verantwoordelijkheid van de regiebehandelaar.

Uitvoering van de BOR op de afdeling

De basishouding van de verpleegkundige tijdens de BOR

In de Generalistische Richtlijn Behandeling (GRB) ontwikkeld door het kenniscentrum Persoonlijkheidsstoornissen (2016) wordt een basishouding beschreven die essentieel is in de begeleiding en behandeling van patiënten met een persoonlijkheidsstoornis, zowel ambulant als in de kliniek. Relevante punten voor verpleegkundigen tijdens de BOR worden hier genoemd.

De basishouding kenmerkt zich door:

- Een bereidwillige, verwelkomende, enthousiaste en hoopvolle benadering zal de verwachting van een succesvolle BOR maximaliseren bij de patiënt.
- Niet alleen behandelaars, maar ook organisaties en afdelingen als geheel moeten enthousiast, hoopvol en verwelkomend zijn. Ze moeten behandelaars genoeg tijd, training, steun en supervisie geven om hun werk goed te doen.
- De ontwikkeling van een goede therapeutische relatie tijdens de BOR wordt bevorderd door een houding van interesse, nieuwsgierigheid, respect, warmte, positieve houding, openheid, oorspronkelijkheid en flexibiliteit. Daarnaast zijn validatie en steun belangrijk, naast confrontatie.
- Een goede therapeutische relatie tijdens de BOR wordt ook bevorderd door actieve betrokkenheid van de patiënt bij het realiseren van de behandeldoelen. Een goede verpleegkundige vraagt van zijn patiënt die betrokkenheid.

- Verpleegkundigen moeten actief zijn, niet observerend en reflecterend op afstand. Een actieve verpleegkundige biedt meer structuur en betrokkenheid, gericht op het willen verminderen van de last van de cliënt. Te neutrale gezichtsuitdrukkingen worden vaker als negatief geïnterpreteerd.
- Verpleegkundigen hebben oog voor de gevolgen van de stoornis op het dagelijkse leven (opleiding, werk, naastbetrokkenen), en ondernemen daar actie op.

(Geïntegreerde Richtlijn Behandeling (GRB) voor de behandeling van persoonlijkheidsstoornissen, Kenniscentrum Persoonlijkheidsstoornissen, Trimbos, 2016)

De patiënt belt en vraagt om een BOR:

- De verpleegkundige gaat telefonisch met de patiënt in gesprek en vraagt waarom een BOR op dit moment nodig is voor de patiënt? In het BOR plan wordt gekeken wat de afspraken zijn over de BOR bij deze patiënt.
- De verpleegkundige kijkt of er een BOR bed beschikbaar is en spreekt af hoe laat de patiënt kan komen.
- Als er geen BOR bed beschikbaar is op dat moment, wordt samen met de patiënt gekeken naar alternatieven.

Opname gesprek bij de start van de BOR op de afdeling:

- Als de patiënt op de afdeling arriveert voor een BOR, wordt de psychiater van de afdeling hierover geïnformeerd. De psychiater heeft geen verdere rol tijdens de BOR maar moet op de hoogte zijn welke patiënten er op de afdeling verblijven.
- De verpleegkundige verwelkomt de patiënt vriendelijk en vraagt naar de aanleiding van de dreigende crisis van de patiënt. Wat is er gebeurd dat er nu een BOR nodig is? De verpleegkundige steunt en valideert de patiënt in zijn gevoelens van angst, spanning en wanhoop.
- De verpleegkundige kijkt samen met de patiënt naar het BOR plan en signaleringsplan van de patiënt en maakt praktische afspraken. Zoals wanneer gesprekken gepland kunnen worden, of de patiënt zijn medicatie mee heeft, etc.
- Er wordt een ontslagdatum en tijd afgesproken.
- Er wordt gekeken wat het doel van de BOR is?
- Wat kan de patiënt helpen om tot rust te komen? Kijk naar mogelijke activiteiten die in het BOR plan staan, of in het signaleringsplan. Help de patiënt deze activiteiten te plannen.
- Afspraken over veiligheid op de afdeling worden genoemd, geen geweld, alcohol of drugs.

Dagelijks gesprek tijdens de BOR tussen verpleegkundige en patiënt:

- Structureer in tijd (15-20 minuten).
- Blijf in het hier en nu.
- Probeer te begrijpen waarom de patiënt gespannen of angstig is.
- Zorg dat de patiënt zich gehoord en gezien voelt.
- De verpleegkundige steunt en valideert de patiënt in zijn gevoelens van angst, spanning en wanhoop.
- Gedachten aan zelfbeschadiging of suïcide zijn geen taboe voor gesprek. Er wordt, vanuit het hier en nu, in het signaleringsplan of BOR plan gekeken wat de patiënt kan doen om spanning te verminderen. Bijvoorbeeld wandelen, in bad, even koffie drinken.
- Voor inhoudelijke gespreksonderwerpen wordt de patiënt naar zijn/haar ambulant behandelaar verwezen.
- Het BOR plan kan tijdens de BOR niet gewijzigd worden. Hiervoor kan de patiënt contact opnemen met zijn/haar ambulant behandelaar.
- Medicatie kan niet veranderd of voorgeschreven tijdens een BOR. Hiervoor kan de patiënt contact opnemen met zijn/haar ambulant behandelaar.
- Reflectie op de eigen gedachten, gevoelens en intenties.
- De verpleegkundige helpt de patiënt om op een bewustere manier stil te staan bij gedachten en gevoelens en om de eigen intenties en de intenties van anderen beter te begrijpen. Verpleegkundigen maken patiënten bewust van het feit dat ze een binnenwereld van emoties en gedachten hebben, die hun gedrag stuurt en waar ze meer grip op kunnen krijgen (GRB, 2016).

Ontslaggesprek BOR:

- Vraag de patiënt wat goed ging, zijn de doelen van de BOR behaald?
- Wat kan de volgende keer verbeterd worden om nog meer van een BOR te profiteren? Zowel door de afdeling als door de patiënt.
- Benadruk dat het gebruiken van een BOR een leerproces is. De volgende keer kan de patiënt weer nieuwe dingen leren tijdens de BOR.
- Spreek af dat de patiënt zelf zijn behandelaar van het ambulante team op de hoogte brengt van de BOR opname.
- Informeer na ontslag de behandelaar van het ambulante team over de BOR opname.

Evaluatie BOR

- De behandelaar van het ambulante behandelteam is verantwoordelijk om het gebruik van de BOR in ieder geval twee keer per jaar te evalueren met de patiënt; en een keer per jaar te evalueren met de patiënt en de kliniek. Als er wijzingen op het BOR plan nodig zijn wordt de afdeling hierover geïnformeerd.

Verslaglegging

- Het BOR plan wordt in het elektronisch dossier opgenomen zodra het is geaccordeerd door de afdeling.
- De BOR staat vermeld in het behandelplan en in het crisis- of signaleringsplan van de
- Gedurende de BOR wordt er door de verpleegkundigen van de afdeling gerapporteerd in het elektronisch dossier.

Level of evidence

Er zijn recent kwalitatieve en beschrijvende onderzoeken verricht naar de BOR als zelfmanagement interventie voor patiënten met BPD (Helleman et al., 2014, 2014a, 2016, 2017; van den Reek & de Muijnck, 2015).
De uitkomsten van de Delphi studie (Helleman et al., 2017) wat betreft de benodigde attitude tijdens de BOR van verpleegkundigen, matcht met de adviezen van het Kenniscentrum Persoonlijkheidsstoornissen in de Generalistische Richtlijn Behandeling 2016. Beiden zijn gebaseerd op expert opinion. Er loopt een grote kwantitatieve studie in Zweden naar de effectiviteit van de BOR, uitkomsten worden verwacht in 2017.
Bij het maken van dit protocol is de structuur van Cuperus aan gehouden, zoals wordt aanbevolen door de V&VN (Cuperus et al. 1995).

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Dankwoord

Dit proefschrift is tot stand gekomen met de hulp van vele mensen, die ik hierna graag wil noemen.

Zonder de inspirerende en betrokken begeleiding van Theo, Peter en Ad waren we niet tot zulke mooie uitkomsten gekomen.

Beste Theo, onder je bezielende leiding is het toch tot een afronding van deze promotie gekomen. Ik heb je interesse, steun en hulp bijzonder gewaardeerd. En je scherpe blik natuurlijk, er waren altijd nog verbeteringen mogelijk. Toen ging je naar Leuven… Maar gelukkig mocht ik mee en konden we samen deze promotie afronden. En Leuven bezoeken was geen straf!

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Beste Ad, jouw ervaring, passie en kennis op het gebied van de behandeling van mensen met een persoonlijkheidsstoornis was onmisbaar. Dit heeft een belangrijke verdieping gebracht. Niet alleen in het onderzoekswerk, maar ook in mijn eigen academische ontwikkeling. De brainstorm en denk sessies waren mij dierbaar. Het ging soms wat snel, “zit je nog achterop mijn fiets”. ;). Ja hoor, maar daar moest ik soms hard voor werken.

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How to thank a research group who makes dreams come true? In the "Brief Admission Skåne Randomized Controlled Trial", the Brief Admission is tested. It is of course fantastic to be able to participate in this Swedish study in Lund and to maintain building, improving and testing this intervention, so it can be used and implemented internationally. Thank you Sofie, Daiva, Sophie and Åsa, for working together in this inspiring project.

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Ten slotte Arjen en Joris, de warmte en gezelligheid van ons gezin was een mooi tegenwicht tegen het vele werk.

Curriculum Vitae

Marjolein werd in Kampen geboren op 23 februari 1975. Na het afronden van de HBO-V aan de Hogeschool Windesheim in Zwolle ging ze als verpleegkundige werken bij Tergooiziekenhuizen te Blaricum, op achtereenvolgens de afdelingen chirurgie, cardiologie/pulmonologie en neurologie. De interesse om actief bezig te zijn met de organisatie en de zorg was toen al aanwezig, wat tot uiting kwam in deelname aan de ondernemingsraad. Na enkele jaren maakte zij de overstap van de somatische zorg naar de psychiatrie en ging op de Intensive Care psychiatrie bij AMC de Meren werken. Na twee jaar volgde de overstap naar de PAAZ van Tergooiziekenhuizen in combinatie met de studie gezondheidswetenschappen aan de medische faculteit van de Universiteit Utrecht, met als afstudeerrichting verplegingswetenschap. Tijdens haar studie was zij voorzitter van de Verpleegkundig Advies Raad. In 2007 heeft zij een uitstap gemaakt uit de zorg als beleidsmedewerker bij Tergooiziekenhuizen met als aandachtgebied de protocollen in het ziekenhuis. Ze behaalde haar doctoraal in 2008. In februari 2009 volgde een aanstelling als buitenpromovenda aan de Radboud Universiteit Nijmegen in combinatie met het werken als sociaal psychiatrisch verpleegkundige in het team Persoonlijkheidsstoornissen van Dimence in Almelo. Deze aanstelling gaf haar de kans om in een combinatie van praktijk en wetenschap bezig te gaan met zorgverbetering op het gebied van de Bed op recept (BOR) interventie voor patiënten met een borderline persoonlijkheidsstoornis (BPS).

Een 3-jarig Summerschool programma voor doctoraal studenten, georganiseerd door de European Academy for Nursing Science EANS, werd gevolgd van 2009 tot 2012. In 2012 heeft Marjolein, samen met Meryem Akbay, binnen Dimence de Innovatieprijs gewonnen voor een project om gedurende 3 jaar verpleegkundige interventies voor de ambulante praktijk te ontwikkelen met een groep verpleegkundigen. In 2013 is de posterprijs gewonnen bij het RPNC World Congress for Psychiatric Nurses, Winnipeg Canada, en in 2015 volgde de publicatieprijs van de Dimence groep.
Tijdens diverse congressen, waaronder het 2nd International congress on Borderline Personality Distorder and Allied Disorders te Amsterdam, heeft zij de uitkomsten van haar onderzoeken over de BOR bij patiënten met BPS gepresenteerd. Hier zijn contacten met Zweedse onderzoekers uit voortgekomen, resulterend in een aanstelling in 2014 als onderzoeker in een onderzoeksproject in Lund, Zweden, genaamd: 'The Brief Admission Skåne Randomized Controlled Trial'. Naast haar functie als sociaal psychiatrisch verpleegkundige bij team Persoonlijkheidsbehandeling te Zwolle is Marjolein ook lid van de zorgprogrammacommissie Persoonlijkheidsstoornissen van de Dimence groep.
Marjolein en haar man Arjen zijn de trotse ouders van Joris.