Evaluation of the Prescribing of Medicines as a Service for People with Personality Disorders

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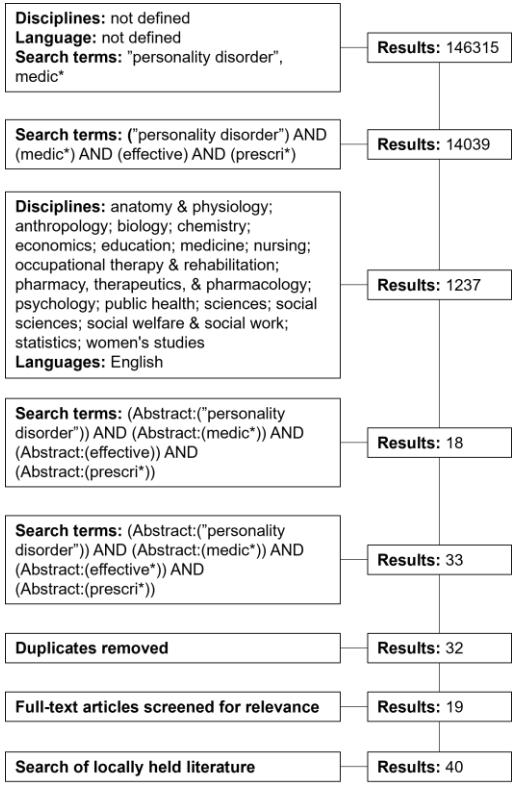
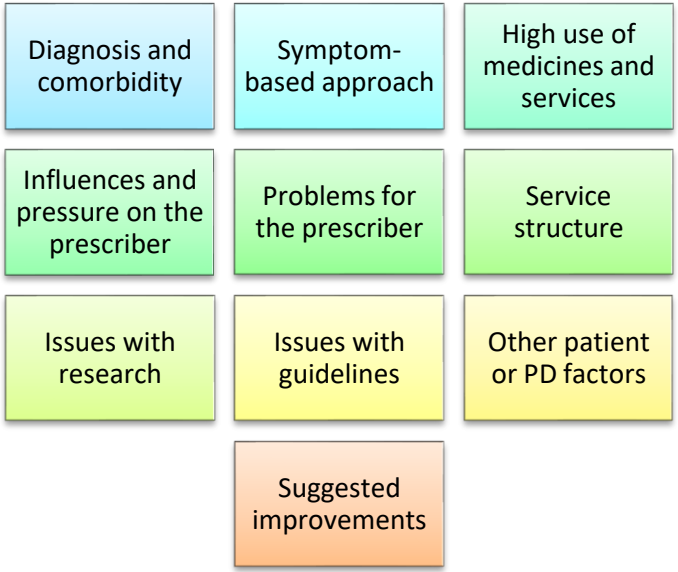
Introduction

- Personality disorders (PD) are conditions associated with long-term patterns of behaviour and inner experience that result in impairments in interpersonal functioning and functioning of aspects of the self.
- No medicines licensed in the UK for the management of PD.
- Two NICE guidelines (Antisocial PD[1] and Borderline PD[2]) recommend that pharmacological treatment should not be used.
- PD is associated with high levels of prescribed therapy.
- **If the guidelines say not to prescribe, why clinicians prescribe? Do they think it works?**

Literature Review



Findings (themed)



Gaps…

- Reasons for prescribing.
- Views of effectiveness.
- Good quality evidence!

Question and Objectives

Service Evaluation Question

Do prescribers consider prescribing medicines to be an effective service for people with personality disorders?

Objectives

1. Explore prescribers' views of the effectiveness of prescribing medicines as a therapy for people with PD.
2. Explore factors that might influence the level of prescribing for people with PD.
3. Identify potential service improvements to the provision of medicines as a therapeutic service for people with PD.

Methodology

- **Design:**
  - Service evaluation; qualitative; interpretive phenomenology.
- **Sample:**
  - 20% consultant psychiatrist workforce (N=14).
- **Recruitment:**
  - Purposive sampling. Advertising and targeted e-mails to eligible staff.
- **Data collection:**
  - Individual semi-structured interviews; using topic guide based on themes from the literature review; remote interviews via Webex (automatic transcription).
- **Data analysis:**
  - Interviews were recorded and transcribed; data were thematically analysed – Braun & Clarke's 6-Phase approach[3].

Ethics

- Beauchamp and Childress' principles for professional ethics were applied, recognising a clinical framework to service evaluation (SE)[4].
  - Respect for autonomy
  - Non-maleficence
  - Beneficence
  - Justice
- Rigour: clear, open study and interview process, with good quality documentation and structured analysis. Clear aim and protocol.

Findings

- Data from the first seven interviews were analysed and themed.
- **Eight themes** were derived, with **twenty-seven sub-themes** – this provided a thematic framework.
- Remaining seven interviews were analysed against thematic framework; the findings were consistent with the derived themes.
- Participant roles covered a broad range of clinical activity:
  - Including inpatient, community, adult and older adult general MH, and non-PD specialities.
  - Only **two** participants reported working in specialist roles with PD.
  - Five participants reported roles with substantial influence over services or colleagues.
- Only **three** participants reported having specialist training or experience.
  - Others exposed to work with PD during general training.
  - Five participants listed training in psychological therapies relevant to PD.
- All participants reported prescribing for people with PD.

Findings – Themes (and sub-themes)

Presentation and diagnosis

- Access to treatment
- Value of diagnosis
- Lack of appropriate diagnosis
- Comorbidity

Roles

- Medicines review
- Other consultant roles
- Team dynamics

Pressures on the prescriber

- Internal
- Patient
- Other external
- Risk and litigation

Choosing to use medicines

- Lack of options
- Situations to prescribe
- Comorbidity
- Polypharmacy
- Not in isolation
- Medicines to access psychotherapies
- Psychological effects of prescriptions

Working with the patient

Evidence and guidelines

Effective prescribing

- Success
- Assessment
- Effectiveness

Improvements

- Collection and use of prescribing data
- Access to specialist services
- Training for staff
- Quality of diagnosis and/or formulation
- Consistency in care approach
- Guidance on choice and use of medicines

Findings:

Diagnosis & Comorbidity

"It's really, really important if there's comorbid illness that we treat it effectively." (PPD06)

"I'm afraid there is a brand of psychiatrist out there who would … not very often diagnose it, because their patients all have 'treatment resistant depression,' 'schizoaffective disorder' and 'bipolar II,' so that they wouldn't prescribe for 'EUPD,' but they would give somebody a cocktail medication for their spurious bipolar II patients… and I think that's quite a difficult concept." (PPD02)

Findings:

Roles

"I think there's still sometimes a culture of 'the buck stops with the doctor.'" (PPD03)

"My personal view is, absolutely, that one of the psychiatrist's roles is to rationalise and deprescribe; however, it's really difficult. It's really time consuming. It doesn't necessarily make you popular." (PPD02)

"Medication is a crutch for somebody with this disorder, and if they want to start walking again, maybe at some stage, the crutches need to be thrown away." (PPD04)

Findings

Pressures on the prescriber

"I think a lot of it is around prescribing, both because that is, I think, the model we've ended up in, isn't it, where GPs, patients, families, colleagues often expect that's what we're gonna do, is fix everything with a medication." (PPD01)

"We may also come under pressure from other people to prescribe; so, other services, for example, or relatives or carers, or, you know, 'My daughter's terribly ill, she's harming herself. Do something, doctor. What are you going to give her?'" (PPD03)

"I think sometimes it's really hard, isn't it, to see people in distress and then not do anything, which I think can be difficult." (PPD01)

Findings:

Choosing to use medicines

"Medication often gets prescribed because clinicians feel hopeless and helpless." (PPD07)

"We all say "Oh, I'd never prescribe that for this" or "I wouldn't just keep adding tablets." We do! And I think that's really interesting. And what is it that means that we go against maybe what we think should happen so much?" (PPD01)

"I guess, acutely and short-term, we do use medication… and overuse it, of course, as well, I would say. Anyone who doesn't acknowledge that in your SE is not telling you the truth." (PPD04)

Findings:

Choosing to use medicines

“We shouldn't underestimate the non-pharmacological effects of medication in the sense the patient comes to you in distress, you’re the doctor or the expert, you listen to them by giving them something, y’know, a prescription; you’re validating their distress or they, they feel they have been listened to, and you're accepting them as a person, so that the rapport improves and if they feel you have listened to them they’re more likely to listen to you. It's a two-way thing.” (PPD05)

Findings:

Working with the patient

"I think, in terms of success, involving patients in their medicine management is really important" (PPD03)

"I think a lot of patients come in with a message that they've been given from primary care that the answer is in a pill... and we just need to try and find the right pill.... And I think, often, if once you've completed the assessment, and you go back to discussing diagnosis and what's wrong and the options... um... often patients are more open to alternatives and, in my experience, patients are often reassured that actually the answer lies inside me - I'm not dependent on, on something outside of me. It can get better with time." (PPD06)

Findings:

Evidence & guidelines

"It [NICE guidance] makes a very clear recommendation that medication should not be used to treat the core symptoms of borderline personality disorder. It couldn't be clearer, actually." (PPD02)

"The bottom line with prescribing is there is no evidence that medication makes any difference to the core features of PD." (PPD07)

Findings: Did the participant consider prescribing of medicines to be an effective service for people with PD?

Response	Number of Participants
Yes (effective)	1
No (not effective)	1
"Yes and no"	2
Does "more harm than good"	2
Not used is isolation	2
A qualified statement (effective in defined circumstances)	5
Don't know	1

"I believe it does more harm than good." (PPD05)

"Definitely not on their own, and definitely not as the only thing you offer." (PPD04)

"…the answer is 'Yes' and 'No.'" (PPD07)

"Can I say sometimes? (PPD03)

Findings:

Improvements

"There's so much data out there, isn't there, that we should be harvesting." (PPD01)

"Ideal would be national or international guidance, and getting a body of research to support that wouldn't hurt, but in the absence of that, local guidance and local support for it, I think, would be helpful." (PPD06)

"Sometimes it's helpful, isn't it, to have that formulary, almost, isn't it, of actually, 'these are the things that can be good,' or just as importantly, the stuff where there's absolutely no evidence – so why are we using it?" (PPD01)

Conclusion

- The SE study has been successful:
  - Determined aspects of practice that are considered to be helpful or impedimentary to care, and identified potential improvements to the service.
- An IP approach to SE, utilising semi-structured interviews, was effective in collecting rich data that addressed the SE Question and Objectives.
- No participants were unequivocally in support of prescribing for PD or opposed to it, most recognising potential benefits in limited clinical situations.

Question and Objectives

Objective 1: Explore prescribers' views of the effectiveness of prescribing medicines as a therapy for people with PD.

- **Achieved.**
- Views varied on effectiveness.

Objective 2: Explore factors that might influence the level of prescribing for people with PD.

- **Achieved.**
- Multiple influences and pressures, inc presentation, service structure, pressure from others, internal feelings.

Objective 3: Identify potential service improvements to the provision of medicines as a therapeutic service for people with PD.

- **Achieved.**
- All participants suggested improvements.

Question: Do prescribers consider prescribing medicines to be an effective service for people with personality disorders?

- No consensus opinion.
- Participants displayed a range of views.
- Recognised benefits and drawbacks.
- All participants suggested improvements - indicating a belief that it is not as effective as it could be!

Recommendations

Specifics

- Improved clarity & consistency in diagnosis.
- Clear purpose to treatment.
- Involve patient in decisions.
- Patient to work with consistent staff.
- Clear communication between teams.
- Clear documentation of info.
- Access to non-pharmacological treatments.
- Training for staff.
- Collection of data for audit, research, service development.
- Routine access to skilled pharmacists.
- Development of local guidelines and/or formulary.

…More generally

- Care must be bespoke to the patient.
- Developments in collaboration with the specialists.
- Share & discuss with others teams.
- Consider patients' views before implementing changes.
- This is only a local SE, but share with relevant groups, including WMDSN

References

1. National Institute for Health and Care Excellence (2009a) *Antisocial personality disorder: prevention and management Clinical guideline*. Available at: www.nice.org.uk/guidance/cg77.
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3. Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101. Available at: https://doi.org/10.1191/1478088706qp063oa.
4. Beauchamp, T.L. and Childress, J.F. (2001) *Principles of Biomedical Ethics*. 5th edn. Oxford University Press.