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Nottingham

A partnership of

The University of Nottingham

and

Nottinghamshire Healthcare NHS
NHS Trust

Positive about mental health and learning disability

Motivating people with personality disorder to engage in treatment

(using a goal-based approach)

Hello again Bergen!

- HM Troopship Dunera, launched 1937
- From 1951, a passenger liner
- From 1961, an educational cruise ship
- Scrapped 1967

Hello again Bergen!

Elgin → Amsterdam → København → Kristiansand → Bergen

Aims

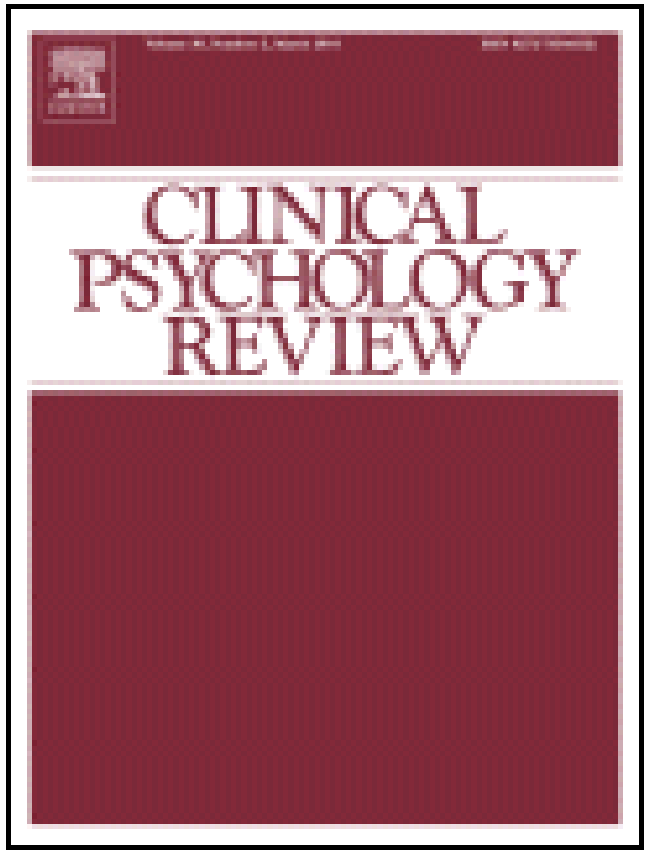
- Why bother about treatment non-completion?
  - Treatment non-completion in treatments for personality disorder and offenders
- What might improve treatment engagement?
  - The Institute of Mental Health, Nottingham, personality disorder engagement research programme

Acknowledgements

- National Institute for Health Research, Research for Patient Benefit (PB-PG-1207-15046)
- National Institute for Health Research, Collaboration for Leadership in Applied Health Research and Care (CLAHRC) – Nottinghamshire, Derbyshire and Lincolnshire (NDL)
- Nick Huband, Lucy Hedges, Mary Jinks, Amanda Tetley, Miles Cox, Eleanor Overton, Eleni Stubbs

Why Bother?

- McMurran, M., Huband, N., & Overton, E. (2010). **Non-completion of personality disorder treatments: A systematic review of correlates, consequences, and interventions.** *Clinical Psychology Review, 30,* 277-287.



Research Questions

1. What is the prevalence of non-completion in PD treatments?
2. What are the correlates of treatment non-completion in PD treatments?
3. What are the outcomes of non-completion?
4. What are people doing to reduce non-completion?

Inclusion Criteria

- Empirical studies
- Psychological treatment for personality disorder
- Adults
- Personality disorder diagnosed using a structured assessment
- AND

1. Correlates of non-completion, OR
2. Outcomes of non-completion, OR
3. Evaluation of intervention to reduce non-completion

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Studies Identified

881 studies identified from search

99 identified as relevant from abstracts

28 studies met the inclusion criteria

28 Studies

- Britain (7), USA (7), Norway (3), Sweden (2), Germany (2), Canada (2), Mexico (1), Italy (1), Netherlands (1), Switzerland (1), and Spain (1)
- Total 2954 participants

Definition of Non-Completion

- Varied
  - Client unilaterally terminates treatment without agreement of therapist
  - Leaving hospital before end of treatment programme
  - Expulsion for rule-breaking or lack of engagement

Rates of Non-Completion

- Median rate of non-completion - 37%
  - Range 15% to 80%
  - Indicates that there are more and less engaging therapies
- Comparable with rates in psychotherapy generally
  - Non-completion 47% (Wierzbiki & Pekarik, 1993)
- Is it a myth that people with PD are poor completers?
- Nonetheless, 37% significantly impacts on service cost-efficiency

Correlates of Non-Completion

- Framework for examining correlates (Barrett et al, 2008)
  - Patient characteristics
  - Practical barriers to treatment
  - Need factors
  - Environmental factors
  - Client's perception of problems
  - Client's beliefs about treatment

Correlates of Non-Completion

- Researchers ignore client perspective, at least in PD engagement research
  - Practical barriers to treatment
  - Client's perception of problems
  - Client's beliefs about treatment
- Treatment non-completion studies
  - focus on largely on what the client is or has
  - ignore how the client thinks and feels about his/her problem, and the treatment on offer

Client Needs Associated with Non-Completion

- Complex PD
- Type of PD? Mixed findings
- Narcissism
- Impulsivity
- Less depressed
- Higher anxiety
- Precontemplation
- Low persistence
- High avoidance
- Poorer problem solving
- Poor ego structure
- Less primitive defences
- Lower level of functioning
- Substance use

Client Attributes Associated with Non-Completion

- Younger
- Lower education
- Lower occupation
- Unemployed
- Juvenile conviction
- Parents divorced before age 10
- Emotional neglect in childhood
- Spending less time alone
- Being in a new relationship

Environmental Factors Associated with Non-Completion

- Less experience with treatment
- Lack of therapist continuity from hospital to community
- Poor treatment contracting
- Poor therapeutic alliance

Correlates of Non-Completion

- A hit-and-miss approach
- Need theories of engagement to drive research

Outcomes Associated with Non-Completion

- Non-completers *versus* completers
- 4 studies
  - Higher hospitalisation rates
  - More hospital days
  - Poorer functioning (global & interpersonal)
- Evidence that non-completers fare worse than treated
- But small sample sizes

Costs Associated with Non-Completion

- Markov Modelling of costs PD offenders in a secure psychiatric facility between 1999 and 2009 (N=95)
- Examines cumulative costs of various states over time (e.g., hospital, prison, community)

£1 = 9 Kr/€1.16/US $1.61

Year	Completers	Non-completers	Difference
1	£25,151	£30,796	£5,645
4	£10,4133	£155,765	£51,632
8	£211,274	£325,026	£113,752
10	£264,303	£402,612	£138,309

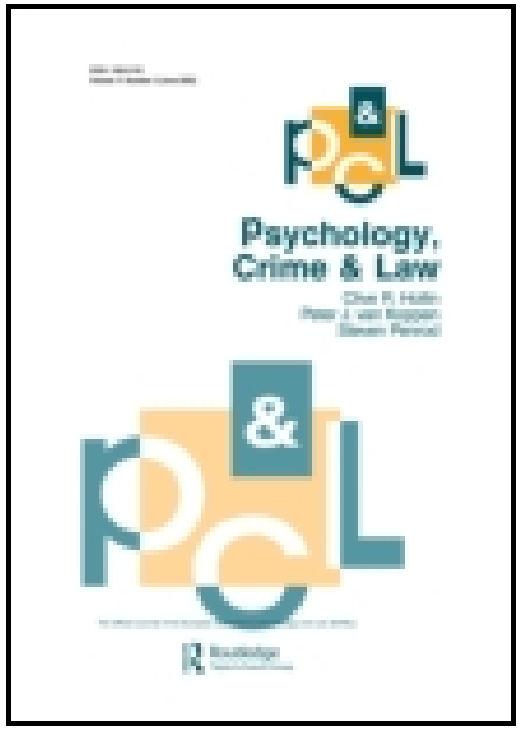
Sampson, C., James, M., Huband, N., Geelan, S., & McMurran, M. (under review). Cost implications of treatment non-completion in personality disorder.

Interventions to Reduce Non-Completion

- Only 2 studies
- Both pre-treatment preparation
- Both studies prepared people for TCs
  - Introduce people to the community
  - Preparation group work
  - Appoint a buddy
- Both reduced dropout
- Need more pre-treatment preparation

Further Evidence on Outcomes Associated with Non-Completion

- McMurran, M., & Theodosi, E. (2007). **Is treatment non-completion associated with increased reconviction over no treatment?** *Psychology, Crime and Law, 13,* 333-343.



Research Question

- Is treatment non-completion associated with increased risk of reconviction over no treatment?

Inclusion Criteria

- Cognitive-behavioural treatment outcome studies
  - Completers
  - Non-Completers
  - Untreated
- Groups unlikely to differ on risk (randomly allocated, risk matched, waiting list control)
- Reoffending or reconviction data

Sample

- Identified 16 studies
- Total 19,563 offenders
- Location
  - Community - 8 studies
  - Detained – 9 studies

Non-Completion Rates

	Total	Institution	Community
Completers	7744	6149	1595
Non-completers	2385	1056	1329
Untreated	9434	5443	3991

Percentage non-completion

Non-Completion Rates

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Completers	7744	6149	1595
Non-completers	2385	1056	1329
Untreated	9434	5443	3991

Percentage non-completion

24%

Non-Completion Rates

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Percentage non-completion	24%	15%	

Non-Completion Rates

	Total	Institution	Community
Completers	7744	6149	1595
Non-completers	2385	1056	1329
Untreated	9434	5443	3991
Percentage non-completion	24%	15%	45%

Outcomes Associated with Non-Completion

- Comparing Completers and Untreated
  → a modest positive effect in reducing recidivism (*d* = 0.11)
- Comparing Non-completers and Untreated
  → a modest but *negative* effect (*d* = -0.16)
- Non-completers are *more likely* to be reconvicted than untreated
  – Effect more pronounced in the community (*d* = -0.23) compared with secure settings (*d* = -0.15)

What is it About Non-Completion?

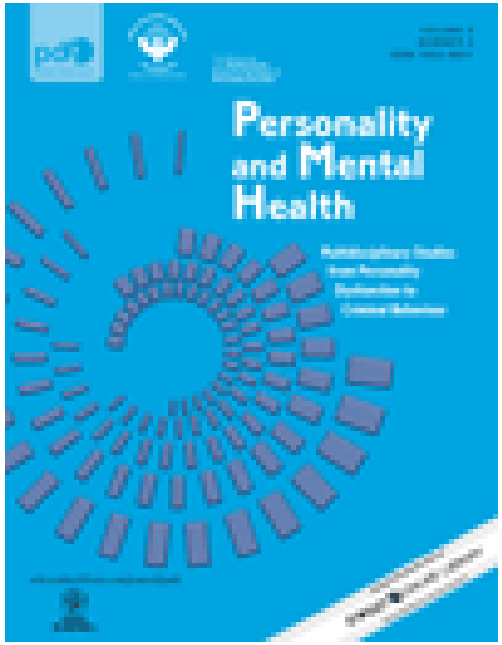
- Non-completers may be complex cases
  - Would do worse anyway?
- Does non-completion make non-completers worse?
  - Dropout → feel unable to change
  - Removal → increase anti-authority attitudes
  - Interruption → problems raised but not solved

The Story So Far.....

- Treatment non-completion is a significant problem
- When researching treatment completion, we need a testable model of engagement to avoid the scattergun approach to research
- Non-completion of treatment is associated with adverse outcomes
- High risk or complex cases may be the ones who do not complete, but there is unlikely to be a single pathway to non-completion
- Non-completion may make some people worse
- We need to take steps to improve the chances that people will complete .... ***particularly***, the high risk ones

A Model of Engagement

- Tetley, A., Jinks, M., Huband, N., Howells, K., & McMurran, M. (in press). **Barriers to and facilitators of treatment engagement for clients with personality disorder: A Delphi survey.** *Personality and Mental Health.*



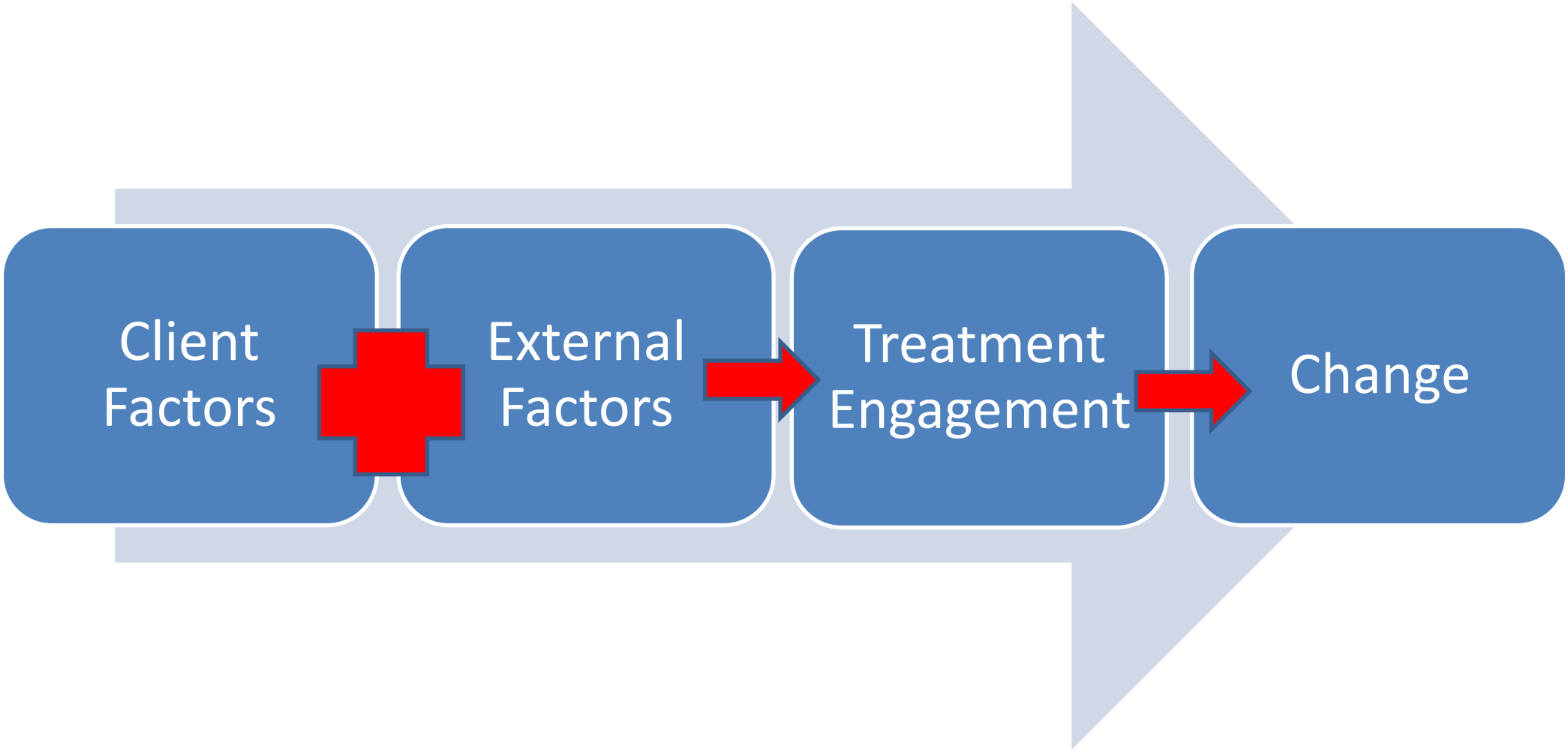
A Delphi Study

- Aim
  - to identify barriers to and facilitators of engagement in services for the treatment of people with personality disorders
- Sample
  - 76 service users
  - 55 clinical staff
  - In specialist PD services, both community and residential; forensic and non-forensic

Interview

- Asked people to identify relevant issues from a range of domains
  - Services
  - Staff
  - Treatments
  - Venue of treatment
  - Service user characteristics
- Based on the Multifactor Offender Readiness Model (MORM; Ward et al.)

Model of Treatment Readiness



Model of Treatment Readiness

Client Factors

Cognitive (e.g., beliefs about therapy)

Affective (e.g., distress)

Volitional (e.g., goal choice)

Competencies (e.g., concentration, emotion regulation, verbal ability)

Identity (e.g., criminal)

Traits (e.g., psychopathy, impulsivity),

Relating (e.g., to therapist, to others)

Other problems (i.e., mental and physical health issues)

Model of Treatment Readiness

External Factors

Personal circumstances

Interpersonal support

Location of services

Availability of therapy when needed

Suitability of therapy premises

Staff training and motivation

Appropriateness of therapy

Client involvement in choice of therapy

Preparation for therapy

Model of Treatment Readiness

Engagement

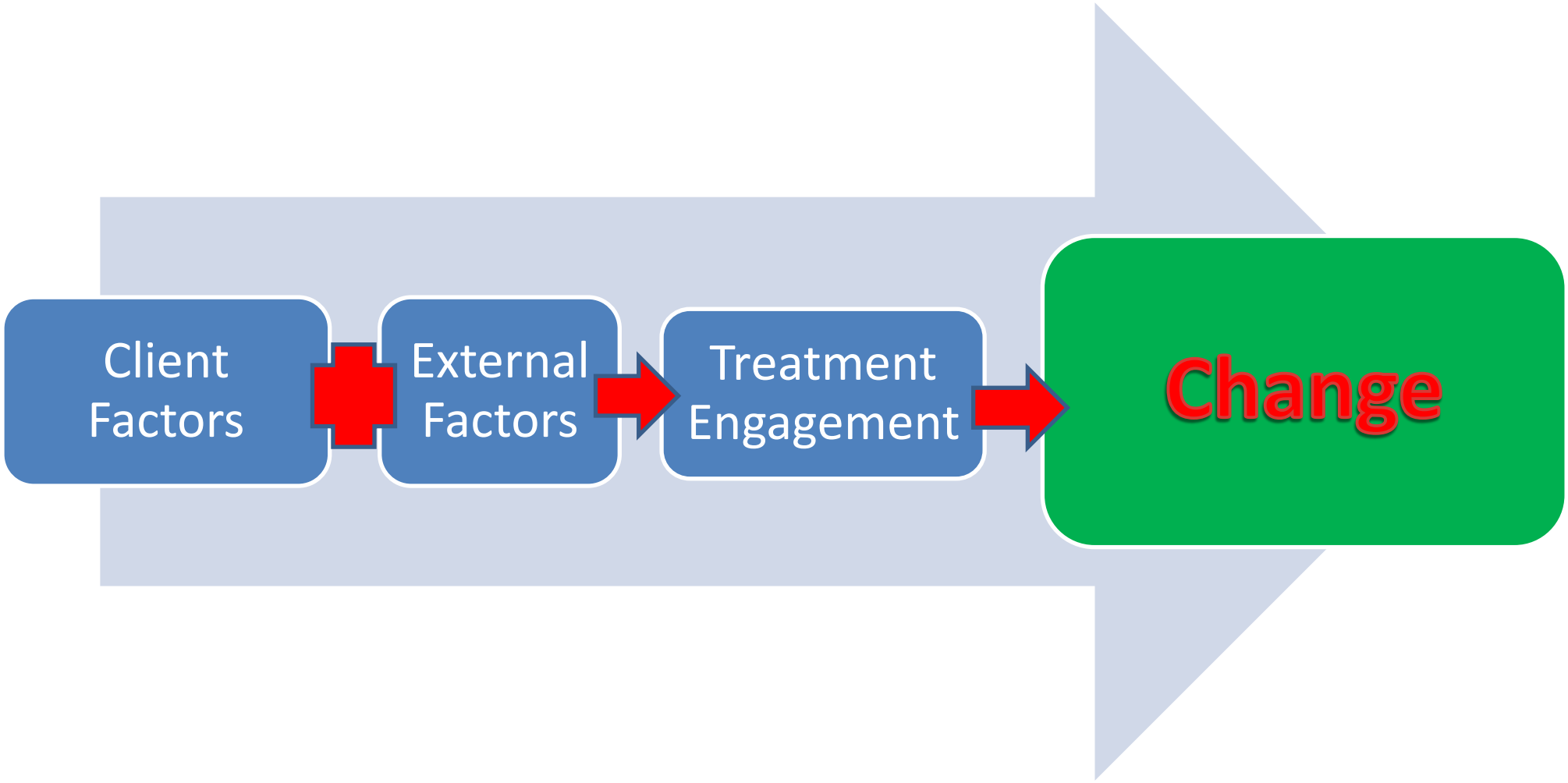
Attendance

Participation

Therapeutic alliance

Low attrition

Model of Treatment Readiness



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Enhancing Readiness

- We are developing a staff training programme based on the Model Of Treatment Readiness (PD) called
- Comprehensive Approach To Enhancing Readiness (CATER)
- Or maybe ...Readiness Enhancement Management Strategies (REMS)

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Pre-Treatment Preparation

Do We Need Pre-Treatment Preparation?

- Some interventions address engagement as part of therapy, e.g., Dialectical Behaviour Therapy
  - Dialectical tactics
  - Obtaining explicit commitment
  - Evaluating pros and cons
  - Devil's advocate
  - Generating hope
  - Subject preparation and role induction

Does Pre-Treatment Preparation Happen?

- Preparation for entry to therapeutic communities (TCs) has been evaluated
  - Introduce people to the community
  - Preparation group work
  - Appoint a buddy
- Reduced dropout

Pre-Treatment Preparation

- In Nottingham, we have developed 3 preparatory interventions for people in treatment for personality disorder
  - Psychoeducation
  - Making Your Emotions Work for You
  - Goal-Based Motivational Interview

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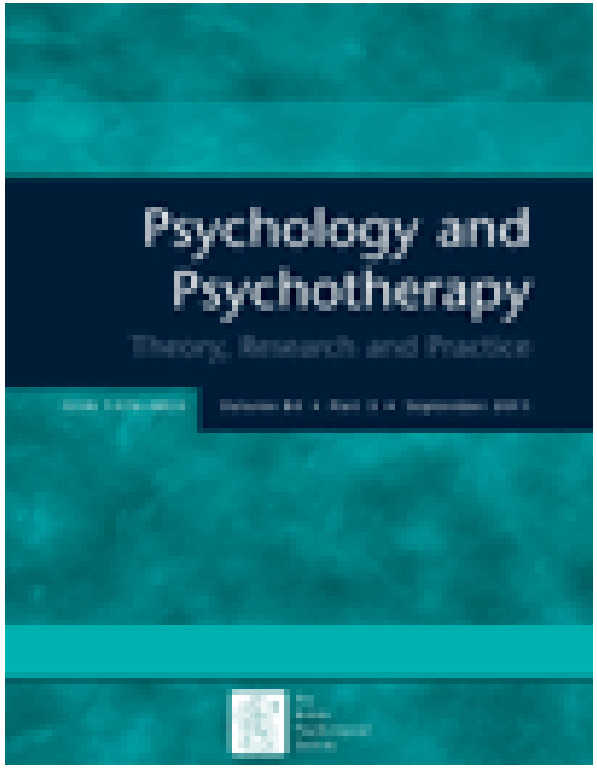
1. Psychoeducation

Psychoeducation

- Banerjee, P., Duggan, C., Huband, N., & Watson, N. (2006). **Brief psychoeducation for people with personality disorder: A pilot study.** *Psychology and Psychotherapy-Theory Research & Practice, 79*, 385-394.



Psychoeducation

- Aims to:
  - establish rapport
  - help client understand their personality traits and associated problems
  - introduce the idea that personality problems can be actively addressed
  - provide the client with a focus for areas of change and agree treatment goals

Psychoeducation

- Up to 4 individual sessions
- Based on International Personality Disorder Examination (IPDE) assessment
  - Clinician explains PD diagnosis
  - Client identifies their own problems in a DSM-IV classification checklist
  - Client identifies which problems they would most like to change

Psychoeducation

- Evaluation
  - 18 inpatients, 16 outpatients
- Knowledge

  - Improved for 25/34
- Helpfulness

  - Most clients found it helpful
- Therapeutic alliance

  - Therapeutic bond
  - Confidence in therapist

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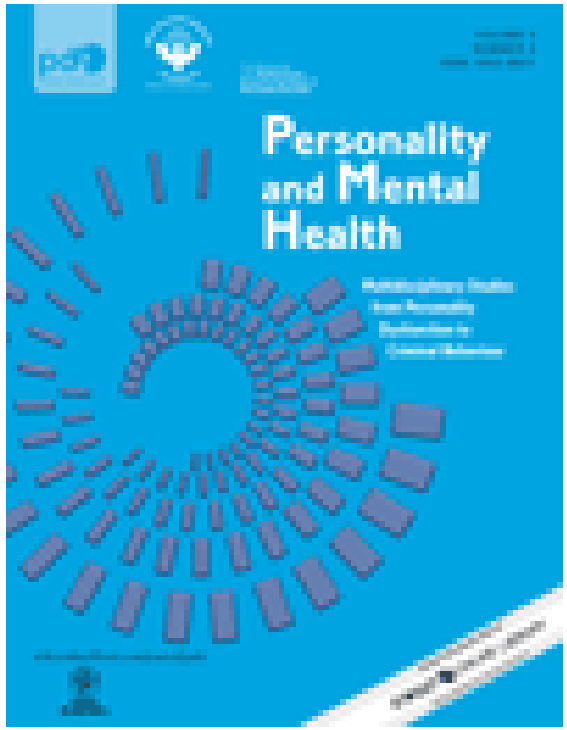
2. Making Your Emotions Work For You

Making Your Emotions Work For You

- McMurran, M., & Jinks, M. (2011). **Making your emotions work for you: A pilot brief intervention for alexithymia with personality disordered offenders.** *Personality and Mental Health* DOI: 10.1002/pmh.170



Making Your Emotions Work For You

- An important aspect of therapies is discussing emotions
- Many antisocial people are not used to doing this
- Alexithymia is of likely importance in treatment engagement

Making Your Emotions Work For You

- Alexithymia
  - difficulty in identifying and describing subjective emotions and feelings (i.e., somatic sensations)
  - difficulty distinguishing between emotions and feelings
  - a limited imaginative capacity
  - an externally-oriented style of thinking
- Associated with schizoid, avoidant, antisocial and borderline personality traits

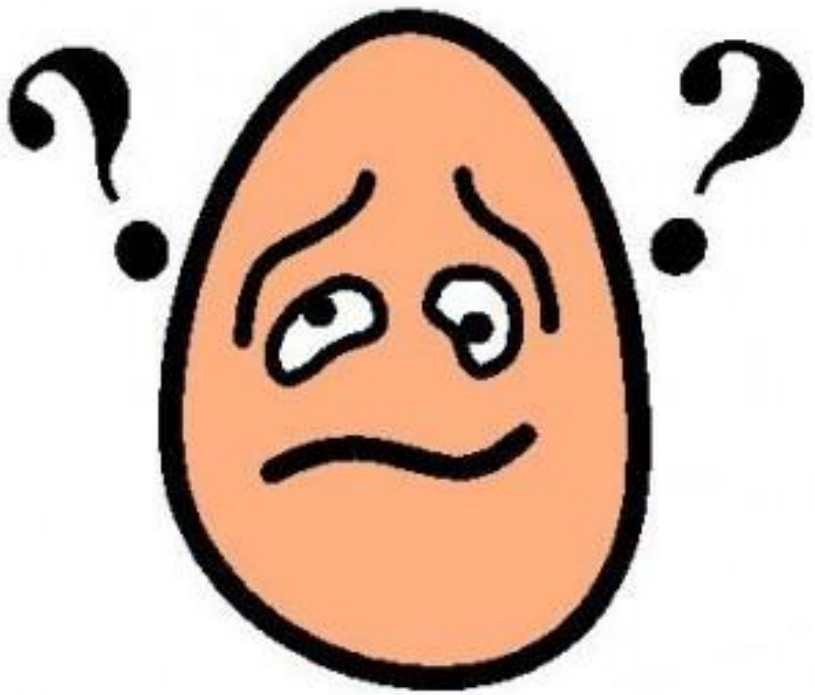
Making Your Emotions Work For You

- Aim to prepare people with PD and alexithymia traits to engage in therapy
- One-day group intervention
- Piloted with 5 male personality disordered offenders in a secure psychiatric hospital

Making Your Emotions Work For You

Comments before the intervention

- *I'm a bit baffled when I get upset and angry.*
- *I find it hard to pick [emotions] out – they are all jumbled up.*
- *Sometimes I find myself over-exhausted and drained because of my emotions.*
- *I recognise my emotions but I try to block them.*
- *I find it hard to show my emotions.*



Making Your Emotions Work For You

- **Psychoeducation**
  - how emotions are identified, and how emotions can be useful in solving problems.
- **Recognising emotions**
  - an experiential component guiding participants in identifying another person's emotions through story-telling and guided imagery.
- **Self-awareness**
  - an experiential exercise, based upon mindfulness techniques, in which participants attend to sensations and emotions.
- **Seeking information**
  - practising the skills of discussing emotions, acknowledging confusion, and asking for information from others.

Making Your Emotions Work For You

- No uniform significant changes on alexithymia (TAS)
- Indications of positive change on the Balanced Inventory of Psychological Mindedness Interest scale
  - beliefs that feelings can offer useful information
- May help people to engage in treatment

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3. Goal-Based Motivational Interview

Goal-Based Motivational Interview

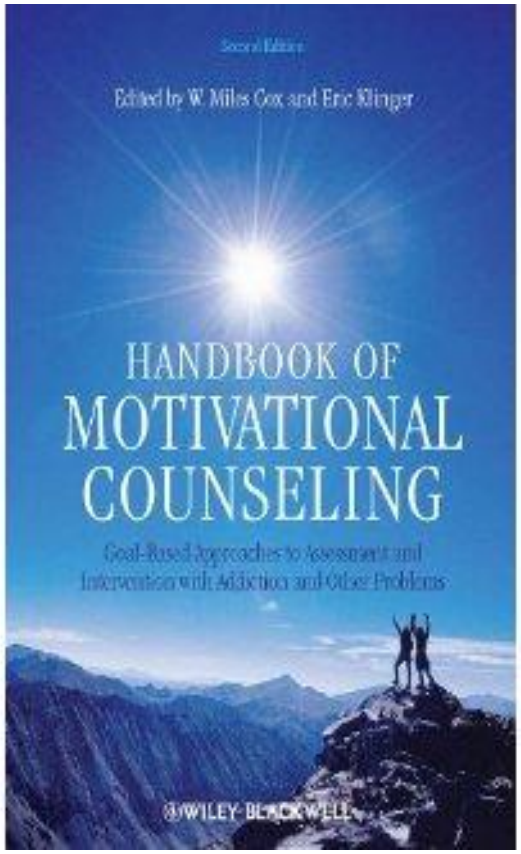
- McMurran, M., Cox, W.M., Coupe, S., Whitham, D., & Hedges, L. (2010). **The addition of a goal-based motivational interview to standardised treatment as usual to reduce dropouts in a service for patients with personality disorder: A feasibility study.** *Trials. 11,* 98.

Goal-Based Motivational Preparation

- Goals are a motivational construct
  - People strive to attain valued goals
  - Different levels of goal
    - Survival
    - Development
    - Actualisation
  - Goal striving varies over time in relation to factors such as need, opportunities, alternative priorities, etc.

Theory of Current Concerns

- W.M. Cox & E. Klinger (eds) (2011). ***Handbook of Motivational Counseling: Goal-Based Approaches to Assessment and Intervention with Addiction and Other Problems,* 2nd ed.** Chichester: Wiley-Blackwell.

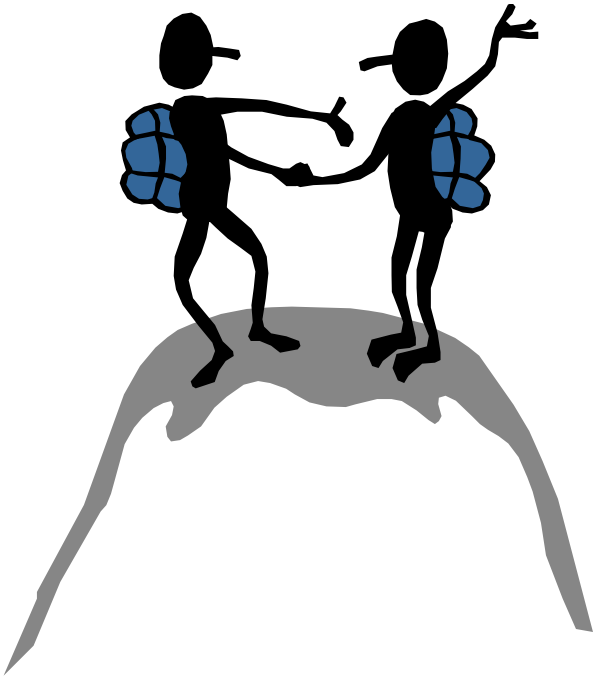


Life Areas

- Home and household
- Employment and finance
- Partner , family and relatives
- Friends and acquaintances
- Love, intimacy, and sex
- Self-changes
- Education and training
- Health and medical matters
- Substance use
- Spiritual matters
- Hobbies, pastimes and recreation

Treatment as a means of attaining valued goals

- Identifying valued goals indicates to people what will make their lives happier and more fulfilling



Treatment as a means of attaining valued goals

- Identifying obstacles to goal attainment can identify treatment needs and highlight the value of treatment

Treatment as a means of attaining valued goals

- Identifying obstacles to goal attainment can identify treatment needs and highlight the value of treatment

Personal Concerns Inventory

- Interview
- Ask client's goals in life areas
- Rate goals on a number of scales
  - Likelihood
  - Control
  - Knowledge
  - Happiness
  - Commitment
- Identify obstacles to goal attainment

1. Home & Household Matters

2. Employment & Finances



3. Partner, Family, & Relatives


4. Friends & Acquaintances

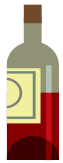

5. Love, Intimacy & Sexual Matters


6. Self Changes and Personal Improvement


7. Education & Training


8. Health and Medical Matters

9. Substance Use



10. Spiritual Matters



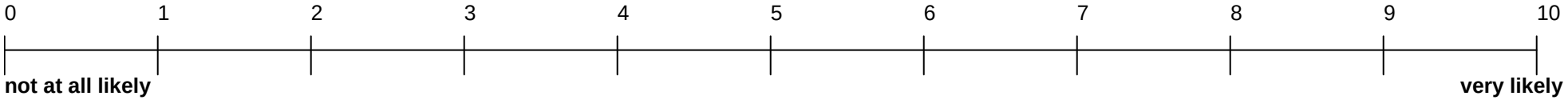
11. Hobbies, Pastimes, & Recreation



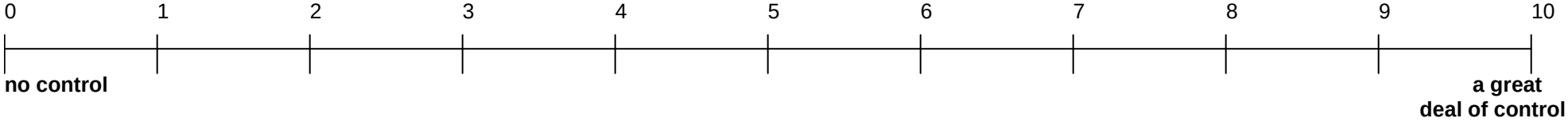
12. Other

Brief description of goal:

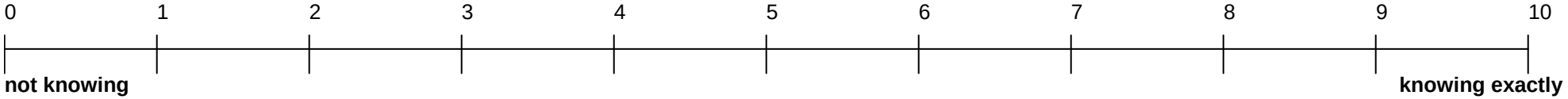
How likely: How likely is it that things will turn out the way I want?



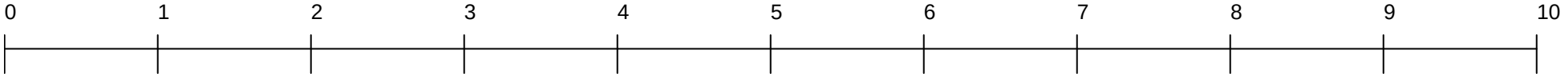
Control: How much control do I have in causing things to turn out the way I want?



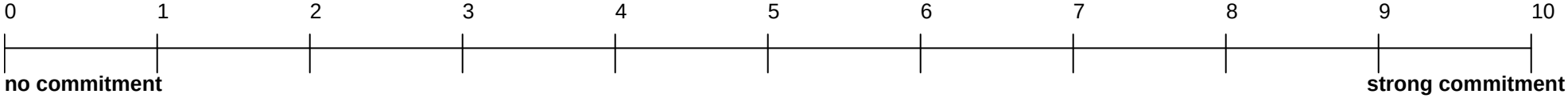
Knowledge: Do I know what steps to take to make things turn out the way I want?



Happiness: How much happiness would I get if things turn out the way I want?



Commitment: How committed do I feel to make things turn out the way I want?



Obstacles: Can you think of any obstacles that will get in the way of you achieving this goal?

Motivational Profiles

- Adaptive
  - High commitment to valued goals
- Maladaptive
  - High commitment to non-valued goals
  - Low commitment to valued goals

Motivational ‘hook’

- Elicit valued goals
  - i.e., lead to happiness
- Identify obstacles to goal attainment
- Obstacles identify treatment need
  - e.g., anger control, substance misuse, relationship problems
- Obstacles identify other social needs
  - e.g., education/training, money management, accommodation

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Prisoners

- An adaptive motivational structure on the PCI is associated with internal reasons for entering programmes
- A maladaptive motivational structure on the PCI is associated with being in the precontemplation stage of change

Sellen, J. et al. (2009). Validity of the offender version of the Personal Concerns Inventory with adult male prisoners. *Psychology, Crime & Law 15*, 451-468.

Prisoners

- PCI as a motivational interview for a Thinking Skills programme
- Prisoners - excluding sex offenders
- Random assignment
  - PCI (N=33)
  - No PCI (N=32)
- Combined staff- plus self-ratings of engagement
- PCI group rated as significantly more engaged

Campbell, J. (2010). Measuring and enhancing offender motivation to engage in treatment and change. Unpublished PhD thesis, UWIC, Cardiff:

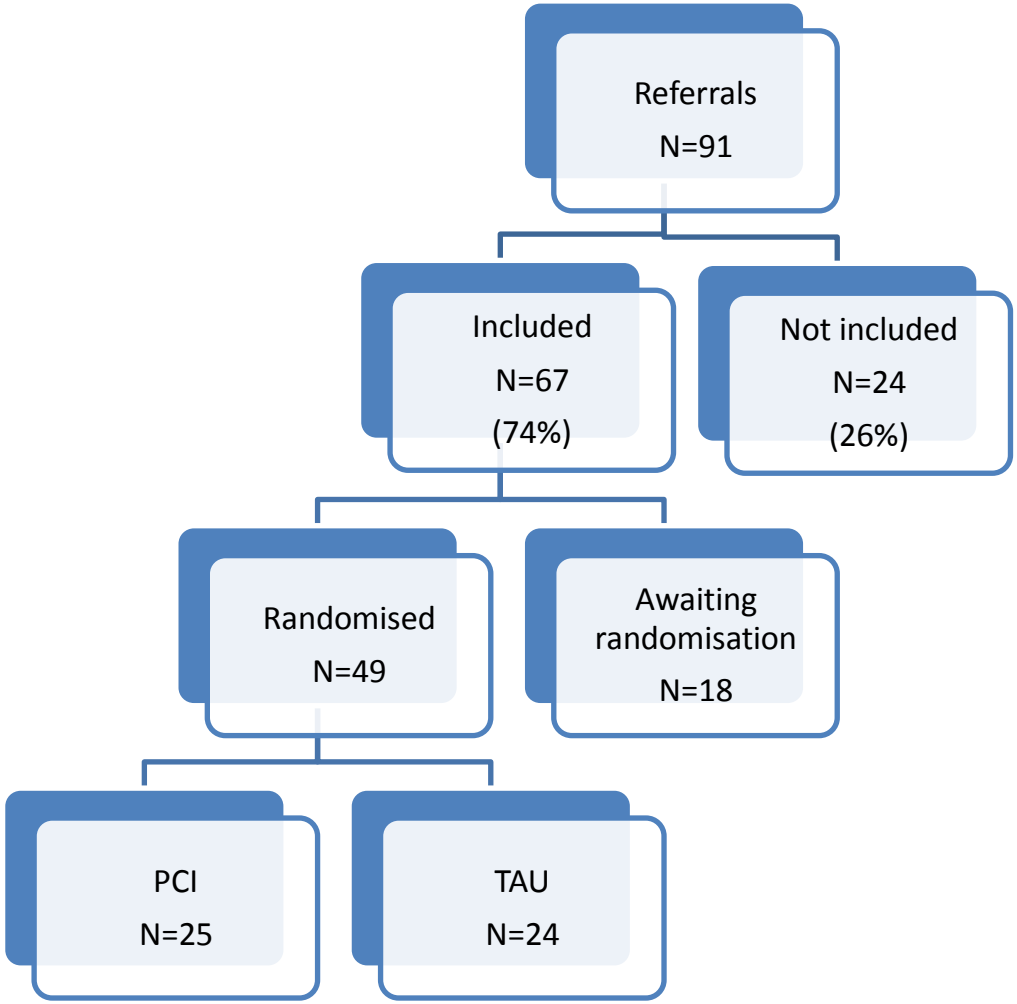
Personality Disorder

- Aim
  - To assess the feasibility of a randomised controlled trial (RCT) to evaluate the effectiveness of the Personal Concerns Inventory in a community personality disorder treatment
  - the recruitment rate to the PCI interview plus treatment as usual or treatment as usual only
  - the acceptability of the intervention to clients and therapists.

Personality Disorder

- An RCT will be considered feasible if
  - the recruitment rate to the project is 54% of all referrals
  - 80% of clients find the intervention acceptable in terms of its practicability and usefulness, and
  - 80% therapists report finding the intervention helpful

Recruitment



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To be continued .....

Conclusions

- Treatment engagement and retention is an important issue
- Non-completion is associated with poorer outcomes and is costly
- Looking for client characteristics that explain poor engagement is only part of the story
- We need to look at our staff, our services, and our treatments

Conclusion

- When client-related issues are relevant to engagement, we should help people prepare for treatment
- Our work focuses on:
  - Psychoeducation
  - Making Your Emotions Work for You
  - Goal-Based Motivational Interview

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Takk skal dere ha!

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