Impact of the Creation and Implementation of a Clinical Management Guideline for Personality Disorders in Reducing Use of Mechanical Restraints in a Psychiatric Inpatient Unit

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ABSTRACT

Objective: To evaluate the impact of the implementation of a guideline for the management of personality disorders on reducing the frequency of use of mechanical restraints in a psychiatric inpatient unit.

Method: This retrospective study was conducted in a psychiatric inpatient unit with 42 beds, which serves an urban area of 330,000 inhabitants. The sample consisted of all patients with a clinical diagnosis of personality disorder (*DSM-IV-TR* criteria) who were admitted to the unit from January 2010 to December 2010 and from January 2011 to December 2011 (ie, before and after, respectively, the implementation of the guideline). The guideline focused on cluster B disorders and follows a psychodynamic perspective.

Results: Restraint use was reduced from 38 of 87 patients with personality disorders (43.7%) to 3 of 112 (2.7%), for a relative risk of 0.06 (95% CI, 0.02–0.19) and an absolute risk reduction of 41% (95% CI, 29.9%–51.6%). The risk of being discharged against medical advice increased after the intervention, with a relative risk of 1.84 (95% CI, 0.96–3.51). Restraint use in patients with other diagnoses was also reduced to a similar extent.

Conclusions: The use of mechanical restraints was dramatically reduced after the implementation of a clinical practice guideline on personality disorders, suggesting that these coercive measures might be decreased in psychiatric inpatient units.

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Coercive measures, such as seclusion or mechanical restraints, are used with violent or agitated patients to prevent them from causing injury to self or others. In Europe, the frequency of the use of coercive measures in involuntarily admitted patients is approximately 38%, with the use of mechanical restraints varying in Western countries from 17% in Sweden to 69% in Greece.[1] Despite their frequency of use, the evidence supporting the use of these measures to control violence is notably insufficient.[2,3] Coercive measures have a negative psychological impact on patients, may undermine the doctor-patient relationship, and, although not well demonstrated, may be associated with clinical complications including death.[4] There is general agreement that the use of coercive measures should be reduced[1,2] or even discontinued.[4] However, most clinical trials focused on reductions of coercive measures tend to show only moderate results.[5–9] Methodological limitations[10,11] are hard to avoid and complicate clinical trials and general research in the field.

Patients with personality disorders are at a high risk for experiencing coercive measures.[1,12,13] The aim of the present study was to assess whether the implementation of a clinical management guideline for severe personality disorders in a psychiatric inpatient unit could reduce the frequency of the use of mechanical restraints.

METHOD

This retrospective study was conducted in a psychiatric inpatient unit with 42 beds, which serves an urban area of 330,000 inhabitants. The sample consisted of all patients with a clinical diagnosis of personality disorder (*DSM-IV-TR* criteria), who were admitted to the unit from January 2010 to December 2010 and from January 2011 to December 2011 (ie, before and after, respectively, the full implementation of the guideline).

The main steps of the process were as follows: one of the authors (M.A.G.T.) prepared a first draft of a clinical guideline after extensive talks with several key staff members, during which their concerns were documented. Through the guidelines, we attempted to address these concerns using an interpersonal understanding of the clinical situations based on Kernberg's group proposals about personality organizations and transference-focused psychotherapy.[14] Several meetings involving key personnel and other staff members were arranged in the last quarter of 2010 (2 per month) to discuss points of disagreement and problems regarding implementation. The goal was to reach a feasible and useful procedure to manage behavioral problems of patients with personality disorders in the unit. Thus, strictly speaking, implementation began gradually in the last quarter of 2010, in parallel to the production of the final version of the clinical guideline. This final version of the guideline was completed at the end of December 2010. The guideline focused on cluster borderline personality disorders. The guideline includes specific recommendations for the therapeutic management of patients across

Clinical Points

- Mechanical restraints can be psychologically harmful for patients and staff, and use should be kept to a minimum.
- A clear agreement at admission between patients, especially those with personality disorders, and staff regarding treatment goals, rights, and obligations and collaboration among staff members may reduce the use of mechanical restraints.

several stages (ie, the emergency department, admission to the unit, follow-up during the stay, and discharge). The guideline does not address the use of coercive measures; rather, it focuses on reducing interpersonal conflicts. The guideline is included in Supplementary Appendix 1.

Nurses routinely recorded the data used for this analysis during the patients' stay. Patients were diagnosed by the psychiatrists, who were in charge of the development and implementation of the treatment plan, starting with a detailed explanation to the patient of the purpose and conditions of the treatment. During the study period, the staff personnel from the unit remained unchanged.

Data are presented using descriptive statistics. To compare the results before and after the intervention, we calculated the relative risk (RR) and the absolute risk reduction (ARR) with their corresponding 95% confidence intervals (CIs) for the use of mechanical restraints and discharges against medical advice. The difference in the mean number of hospital stays with its corresponding 95% CI was also calculated. All of the analyses were performed using the statistical package SPSS, version 20 (IBM Corporation, Armonk, New York). The study design was approved by the Ethics Committee of Basurto University Hospital, Bilbao, Spain.

RESULTS

A total of 878 patients were admitted to the unit during 2010, 87 (9.7%) with a diagnosis of personality disorder. The corresponding numbers for 2011 were 871 and 112 (12.9%), respectively. Cluster B personality diagnoses comprised two-thirds of the sample in both years, with borderline personality disorder being the most prevalent. Proportions did not show significant differences. The patients included young adults, with a slight predominance of males in the year before the intervention; only a minority were married or had a stable partner, and only a minority were active (Table 1). Regarding clinical characteristics, there were no relevant differences between the patients before and after the intervention (Table 1). Specifically, the number of previous admissions, previous suicide attempts, use of drugs, or family psychiatric history did not show statistically significant differences.

The proportion of patients with personality disorders requiring mechanical restraints in the unit was reduced from 38 of 87 patients admitted before the intervention (43.7%) to 3 of 112 patients admitted in the year after the intervention (2.7%), for an RR of 0.06 (95% CI, 0.02–0.19) and an ARR of 41% (95% CI, 29.9%–51.6%). There were no significant differences in the duration of stay between the patients before and after the intervention (Table 1). However, the risk of being discharged against medical advice increased after the intervention, with an RR of 1.84 (95% CI, 0.96–3.51). There was also a reduction in the use of mechanical restraints in patients without a diagnosis of personality disorder, from 43% to 4.3% (RR of 0.10; 95% CI, 0.07–0.14; ARR of 38.6%; 95% CI, 34.8%–42.5%). In these latter patients, there were no differences before and after the implementation of the guideline in the length of stay (15.8 vs 15.1 days) or in the proportion of patients who were discharged against medical advice (4.4% vs 3.8%).

DISCUSSION

Use of mechanical restraints in patients with personality disorders admitted to a psychiatric inpatient unit was dramatically reduced the year after the implementation of a clinical management guideline on personality disorders compared to the previous year. This result was accompanied by a slight increase in the risk of being discharged against medical advice. The reduction appeared gradually; in fact, it started during the implementation period at the end of the first year of the study.

The frequency of the use of mechanical restraints in patients with personality disorders in our unit before the implementation of the guideline (43.7%) was similar to the rate reported in a previous study with 2 Spanish centers in 421 patients who had several psychiatric diagnoses (37%)[1] and to the rate reported in patients who had borderline personality disorders (35%) in a state psychiatric hospital in New York.[13] The implementation of the clinical guideline practically abolished the use of mechanical restraints in the year after its implementation, suggesting that this may be an effective intervention for reducing the use of coercive measures with psychiatric inpatients. Other specific programs for patients with personality disorders, such as establishing a specialized ward, have also been effective for reducing the use of coercive measures with psychiatric inpatients.[15] However, in our study, the reduced frequency in the use of mechanical restraints was also evident for patients with psychiatric diagnoses other than personality disorders. This finding suggests that, to a great extent, our results could be attributed to a nonspecific effect of the implementation of the guideline, for instance, a change in the therapeutic environment, which has been shown to be effective in reducing the use of coercive measures in previous studies.[16] This fact is consistent with the opinion that the use of coercive measures is based more on cultural factors or policies than on medical or safety requirements.[1,17]

These results go beyond our expectations, and we do not fully understand the causes behind such an important effect. However, we think the fundamental ingredient might be the team approach to design and implementation (ie, the process itself). Many staff members participated in the creation and dissemination of the guideline and developed a new clinical attitude. Rather than using a top-down procedure ("we have designed this excellent guideline and you should now apply

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Table 1. Characteristics of Patients With Personality Disorders and Their Clinical Outcomes Before (n = 87) and After (n = 112) the Implementation of a Clinical Management Guideline on Personality Disorders

Variable	Before (2010) (n = 87)	After (2011) (n = 112)	Effect Size
Demographic and clinical characteristics			
Age, mean (SD), y	38.5 (13.3)	38.0 (12.9)	…
Female, n (%)	34 (39.1)	57 (50.9)	…
Married/stable partner, n (%)	10 (11.5)	19 (17.0)	…
Employed, n (%)	3 (3.4)	11 (9.8)	…
No. of previous admissions, mean (SD)	4.8 (2.7)	4.5 (2.7)	…
Voluntary admission, n (%)	80 (92.0)	105 (93.8)	…
Clinical outcomes			
Use of mechanical restraints, n (%)	38 (43.7)	3 (2.7)	RR: 0.06 (95% CI, 0.02 to 0.19) ARR: 41% (95% CI, 29.9% to 51.6%)
Discharge against medical advice, n (%)	11 (12.6)	26 (23.2)	RR: 1.84 (95% CI, 0.96–3.51) ARR: −0.11% (95% CI, −0.21% to 0.00%)
Duration of stay, mean (SD), d	10.5 (9.4)	10.4 (9.2)	0.2 (95% CI, −2.4 to 2.9)

Abbreviations: ARR = absolute risk reduction, RR = relative risk.

it in your clinical practice"), we tried to use a bottom-up procedure. There was a previous specific interest in our unit about management of patients with personality disorders and of situations that ended in the use of mechanical restraints; so, the guideline and its dissemination became a logical next step in an ongoing evolution and was welcomed by the team. Regarding the generalization of the effect to all patients, it is possible that staff members have extended their new attitude to all kinds of patients in the ward. This is a logical process, as many of the suggestions included in the guideline involve general principles that can be very naturally applied to patients without personality disorders.

It is important to keep in mind that we are not practicing a new way to deal with violent behavior. We are approaching patients with personality disorders with a different attitude that seems to reduce violent behavior. Once violence appears, we act as before, using the traditional responses common to most inpatient units: reduction of stimuli, verbal support-holding, permanence of the patient in his/her room (with or without the company of a staff member, depending on the case), medication, and/or mechanical restraint as a last resort intervention.

The increased risk of being discharged against medical advice that occurred after the implementation of the guideline raises some concern. Reasons for this type of discharge, especially in the second year of the study, were mainly due to failure of the patient to maintain the conditions of treatment agreed upon at admission. Issues regarding drug use, respect to other patients and staff, and participation in therapeutic activities were common in those cases. Patients who are discharged against medical advice are at a greater risk for readmission and show poorer outcomes on a number of dimensions of functioning.[18]

The major limitations of our study are its observational design and the lack of a concurrent control group. In addition, our encouraging results should be replicated with larger samples and in other settings, and the stability of the results across time as well as the long-term clinical outcomes should be further evaluated. We consider the guideline as a means through which a much-needed discussion and collaboration process was established among staff members, collecting some of the existent anxieties and giving our professionals a new way of dealing with interpersonal conflicts with patients. A possible replication of this study would require as a key factor a repetition of the whole process of guideline collaborative construction and not just the dissemination of the document itself. Mechanical restraints are the end result of an interpersonal conflict with many intervening factors. Every treatment team in every inpatient unit lives in a specific atmosphere with individual and group differences that should be addressed if we are to change long-standing behaviors. In the meantime, the results of our study suggest that an important reduction in the use of mechanical restraints in psychiatric inpatient units can be possible.

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Supplementary material follows this article.

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Supplementary Material

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List of Supplementary Material for the article

1. **Appendix 1** Clinical Management Guideline For Patients With Severe Personality Disorders

Disclaimer

This Supplementary Material has been provided by the author(s) as an enhancement to the published article. It has been approved by peer review; however, it has undergone neither editing nor formatting by in-house editorial staff. The material is presented in the manner supplied by the author.

CLINICAL MANAGEMENT GUIDELINE FOR PATIENTS WITH SEVERE PERSONALITY DISORDERS

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INTRODUCTION

Patients with Severe Personality Disorders (SPD) live in a reality with elevated levels of emotional intensity and exhibit difficulty in recognising and controlling their affects, finding themselves overwhelmed by the often changing and contradictory emotions that consume them. That emotional intensity inevitably taints their interpersonal relationships, which become scenarios in which behavioural patterns manifest themselves, patterns which tend to bring certain conflicts and which include upset feelings that are expressed through actions when they could be expressed by words. These people have a diminished ability to put themselves in other people's shoes or sense the other person's mental state, and they can even possess a reduced ability to self-observe and examine their own emotional reactions and behaviour from a distance.

Obviously, all of this affects the patient-therapist relationship, which is a special form of interpersonal relationship. Two characteristics of this therapeutic relationship make it easy for the described phenomena to occur within this context, with the greatest of ease and intensity.

1. Crisis and/or Vulnerability. Therapist-patient contact generally comes about in a moment of crisis in which the emotions of the patient are particularly intense and overwhelming, which means there is a greater possibility of there being difficulties in the relationship. At the same time, this encounter is always brought about in conditions of great vulnerability; the therapeutic relationship implies an assumption of an inability to completely control one's situation and thus evokes in the patient anxiety, mistrust and fear of abuse.
2. Asymmetry. The therapeutic relationship, as opposed to a normal social relationship, involves an enormous asymmetry; one person—the patient—seeks help and another —the therapist—gives it; one reveals his or her life story and the other explores it, and above all else, one person suffers—and causes suffering—while the other does not. This peculiar condition of the professional health worker-patient relationship, which is difficult to endure for anyone, is particularly problematic for these patients, making it even easier in these cases for the intensity of the usual relational difficulties to come about.

In the present case, all of the above multiplies whenever there is a situation that is especially critical, such as when attention is being given in emergency departments and in the patients' admission and stay in a inpatient unit. This moment tends to be one of maximum crisis; the mistrust upon entry, the fear of staff and the fear displayed towards the other patients, the loss or limitations of liberties all add up to produce the ideal conditions for bringing about this array of relational difficulties that these people endure.

There is one interpersonal characteristic that is worth mentioning as it is key in understanding the behaviour of subjects with SPD in the health care environment. The emotional intensity that they undergo, and their difficulty in simultaneously perceiving the positive and negative aspects of others (splitting) make it easier for the interlocutor—in this case, the clinician—to sometimes identify with, or to almost always react with great intensity to the patient and the position in which the patient has put him or her. The result can tend to be hastily made rash decisions which may reflect the poor mood of the professional as well as defensive attitudes on his/her part, which would not favour the optimal development of the case and which bring about premature conclusions to treatment, and the subsequent difficulties of starting the process over again. What happens frequently is that, after the therapeutic relationship is ruptured, the professional is left with a sensation of bitterness and upset: with feelings of both ambivalence and relief in finding him or herself freed of this troublesome patient, and feelings of upset in recognising the aggressiveness that was displayed during the encounter with the patient; aggressiveness that is often difficult to avoid but which ideally should never come up in clinical decisions.

A majority of SPDs correspond to patients that suffer Group B PDs (Dramatic personalities; Narcissistic, Hysterical, Antisocial and Borderline PDs). So the variety of literature dedicated to the approaches to these disorders, particularly to Borderline Personality, could serve us as a guide.

The inpatient attention given to SPD cases makes up a helpful element in the therapeutic process of these patients. The key element in treatment is a long and intensive psychotherapeutic process, usually developed in an outpatient facility, together with the judicious and eventual usage of psychotropics that address specific symptoms. Inpatient admission serves solely to facilitate the resolution of a crisis or to address a comorbid pathology (Affective disorders, Anxiety disorders, Substance abuse disorders, Eating disorders, etc).

We propose four principles that should govern the relationship of the professional with a patient who has SPD, summarized in the acronym STTH

Security. The clinician should feel secure when interviewing the patient and therefore he or she should not proceed whenever those security conditions have not been met. If necessary, we shall wait until health personnel or security accompanies us, and we will postpone the interview whenever it is so needed. An intimidated clinician CANNOT properly evaluate a case and thus cannot give the patient the treatment he or she needs and deserves.

Training. The clinician should know the pathology he or she is treating, especially in situations of high complexity and demand such as this one. Continuing education in this area is key.

Time. The attention given to these patients requires some time for all of its phases. There is no such thing as brief attention when it comes to SPDs, and the clinician should not allow him or herself to be influenced by pressures coming from either the patient, the surroundings or from the very organisation where he or she works.

Humility. All clinicians need a certain minimum of conditions to be met in order for a session to be effective. These conditions should be implemented by the institution, the clinician him or herself and the patient. Whenever this minimum of conditions has not been met, the clinician should humbly acknowledge his or her inability to treat the patient and put a stop to treatment, redirecting the patient or postponing the session until these conditions can be met. When the patient shows a particularly low level of collaboration, making progress impossible through his or her lack of attendance, compliance, respect, self-control, etc, we will have to face the possibility of halting the treatment that is taking place.

Patients with SPDs, due to what has been mentioned above, tend to question and transgress the normal limits of interpersonal relationships, especially in therapeutic relations. In order to manage these breakdowns of those limits it is necessary to establish clearly to the patient what those limits are as well as what the consequences will be for overstepping those limits. Likewise, any therapy session, and especially inpatient care, should be preceded by a detailed statement on the treatment structure as well as the obligations and tasks that each of its parts will entail. Without those conditions the treatment may not be possible, and therefore the clinician should occasionally acknowledge his inability to work under such circumstances, and halt the treatment in progress.

Below we will go through possible guidelines of action in the process of providing hospital care to these people, from their arrival at the emergency department up to their discharge from the inpatient unit -guidelines which should serve to reduce the aforementioned problems. It is important to take into account that the nature of the pathology being addressed makes interpersonal problems inevitable and thus makes it impossible for a real clinical situation to reach a point of "zero conflict". The objective of these recommendations is to provide guidelines to professionals regarding ways to proceed that facilitate the process, bringing about less unrest in them, and above all else, increasing the possibility for the hospital stay to be useful for the patient.

1. EMERGENCY CARE
    a. Objective. Evaluate the case in order to decide if we will proceed to
        i. Discharge and Outpatient Follow-up.
        ii. Admission. Voluntary or Involuntary.
    b. Process
        i. Evaluation. The clinician should be guided as much by the transversal vision of the punctual examination of the emergency as he or she is guided by, above all else, the longitudinal information that can be gathered. Information collected from family members and close relations could be of importance. Specifically, we should gather information on interpersonal relationships to significant figures (family, intimate friends, partners) which should reflect with greater clarity the basic patterns of behaviour in these persons. Additionally, it is key that information be collected regarding dangerous behaviour which may influence decisions regarding the need for admission (self-harm or harm of others, substance abuse, transient psychotic disorder, the patient being in a critical self-destructive situation in his or her life. . .) as well as information regarding the history of past therapies and their development (types, sessions held, eventual dropouts and their causes). To that end, the clinician should have a clear vision of:
            1. The current clinical situation, with primary symptoms, provisional diagnosis/diagnoses.
            2. Prior development, basic interpersonal tendencies.
            3. Treatment received and responses to it
            4. Risks that determine the need for admission.
        ii. Discharge with therapeutic advice. The clinician will consider if the patient does not present a critical situation that would require admission. The following actions will be carried out
            1. Education. The information contained in points 1 to 4 of the above paragraph is given to the patient, and if necessary to his or her relatives, explaining the reasons behind our decision.
            2. Psychopharmacological Treatment. For alleviating certain symptoms, if required at that moment. It is advisable that Psychopharmacological Treatment be kept at a minimum given the frequent tendency of misusing medication in these cases. Provide

sufficient medication up to the outpatient visit that should normally take place.

3. Advice. Explain to the patient what is the treatment we think is necessary, based on a lengthy clinical therapeutic relationship, the difficulty of it, the need of his or her effort as a fundamental basis, the usual problems that should be expected In addition, we will explain to the patient where he or she should go, what formalities he or she should go through, and when he or she should go through them. Obviously, all practical details should be included in the report given to the patient upon his or her discharge from the emergency department.

iii. Admission. Voluntary or Involuntary. If the clinician deems the situation to be especially critical and that the outpatient treatment is insufficient to bring it under control, he or she will make the decision to admit the patient to the unit. To that end

1. Outline of the Conditions. The patient will be told the conditions of admittance (detailed further on). A dual message is fundamental
    a. Objectives of admission. To alleviate a crisis situation. A hospital admission will not cure a patient with an SPD. It is a temporal phase in a long process of treatment. This message should be directed as much to the patient as to those interested parties around him or her.
    b. Conditions of admission. Failing those conditions, the treatment will not work. Collaboration is strictly required, as it is essential if progress is to be made. If no such collaboration is given, this becomes impossible.
2. Commitment from the Patient. The patient should accept the conditions and objectives clearly, and his or her commitment should be collected in writing for the record. Obviously, the patient should accept that, failing these conditions, treatment will remain at a standstill. We should avoid any punitive connotations when providing these explanations; the reality is that, just as one would not perform major surgery without the patient accepting anaesthesia, it is likewise not possible to treat a SPD patient without the patient accepting a certain minimum of working conditions.
3. Decision regarding involuntary care. If the patient accepts the conditions after they have been explained in detail, he or she will proceed to admission. If he or she does not accept the conditions, the clinician should think about the need for inpatient admission, considering the possibilities available: discharge from hospital, clinical outpatient follow-ups, or involuntary inpatient care. Obviously, if admission is involuntary, the expectations for therapy will be limited so long as the absence of collaboration persists; the objective would basically be to lessen the symptoms related to more immediate risks and later to move onto discharge and outpatient treatment.

Given the complexity of these cases, for each one of the SPD patients that they attend, Psychiatric Residents in their 1st, 2nd and 3rd year will have to confirm their clinical decisions with the psychiatrist on call.

2. ATTENTION AT INPATIENT UNIT

a. Voluntary inpatient treatment is based on a therapeutic contract that the patient examines in detail and then accepts. The patient will be made aware of the contract at the earliest moment possible, ideally at the same emergency department or during the earliest hours of his or her hospital stay. This agreement will require objectives and conditions for the stay, with tasks and obligations for the patient and the professionals, as well as consequences for any breach of this agreement.
b. Who Treats the Patient. Changes in the treating staff should be reduced to a minimum, for the purpose of decreasing the possibility of interpersonal conflict. The Physician in Charge (PIC), ideally, should be the same throughout the entirety of the process. Whenever possible, there

should also be a member of the nursing team in responsible of the case, a person who would be the interlocutor of the patient for matters related to that area. If the PIC or any other staff member feels an emotional reaction towards the patient that cannot be managed properly, he or she should make the situation known as soon as possible to the corresponding supervisor, who will eventually decide the changes needed in patient assignation. The complexity of these cases suggests that, whenever possible, each doctor in the unit should not at any given time attend more than one patient with these characteristics. On the other hand, professionals who do not wish to have patients with SPD should not take care of them.

c. SPD Discussion Group. Work with these patients is particularly complex and the existence of a time and place where reflection can be had as a group, regarding the circumstances of admission, and the development thereafter, is an absolute necessity. A working group will be formed which will meet on a weekly basis to evaluate the SPD cases in the unit. All of the PICs involved will participate in the discussion as will be the Section Head of the Unit, the Head Nurses and the Adult Inpatient
Clinical Psychologists. Besides them, any member of staff is encouraged to attend the group anytime he or she needs to discuss problems with these patients. The objective of this group will be to analyse and resolve the difficulties that could be brought about at the group level by these patients, providing solutions aimed at improving therapeutic atmosphere and reducing the harmful effects that this clinical task may entail for the group.

d. Objectives. They should be specified within the first hours. In general terms, they will consist in alleviating the crisis and/or treating the comorbid pathology. It is important that these objectives be made known to the patient, his or her associates and the team. Advantage should also be taken of the stay in order to educate the patient regarding his or her illness, his or her therapeutic options, the personnel resources that he or she can utilise and the steps that are to be taken upon discharge.

e. Inpatient Treatment Conditions.
    i. Respect. The patient should be treated with respect. Likewise, he or she should also show respect for the rest of the patients, the visitors and families, and, of course, for the professionals. Failure to comply with these conditions could put treatment at risk to the point that it becomes impossible.
    ii. Violence. No form of physical violence is permitted in the unit, nor is any relevant form of verbal violence.
    iii. Activity Schedule. The schedule will be communicated to the patient in the emergency department or in a manner immediately following admission. The schedule is the same as the one for the rest of the patients.
    iv. Participation in Activities. idem.
    v. Smoking. idem. If the patient is an avid smoker, the limitations set for this activity should be mentioned to him or her at the emergency department. The patient may be given nicotine patches and like everyone else should be allowed to smoke in the garden.
    vi. Garden. The same hours as the rest of the patients.
    vii. Visits. This will be decided as in the other cases.
    viii. Interviews. It is particularly important that the nursing staff know, in detail, the therapeutic objectives established as well as the eventual progress and evolution. The participation of a nurse in these interviews, together with the PIC, can be of help to that end.
    ix. Discharge Against Medical Advice (AMA). This is solely decided by the PIC. In all aspects that are problematic, the PIC should be the one to make all of the relevant clinical decisions, avoiding a situation in which professionals who barely know the patient are faced with complex decisions that could potentially have negative

consequences for the treatment. AMA discharge is a breach of the commitment on the part of the patient and should bear the consequence that the patient not return to the inpatient unit for a set period of time (four months). In this period, only the most extreme conditions should make admission advisable, and should always have very specific objectives. In such a case, whenever possible, it would always better to opt to extend the stay in emergency unit (if the patient arrives there) care or to carry out inpatient admission for a short duration.

x. The Role of the Psychiatrist on Call. The Psychiatrist on Call should bring about the application of this guideline, diverting to the PIC the definitive clinical decisions regarding the case. It would be preferable that the regular therapist be the one to make the definitive decisions, especially those that concern the continuance of treatment.

f. Relations with Family. The PIC will interview the family and relatives in order to obtain relevant information as well as to procure collaboration in both present and future treatment.

g. Relations with the Outpatient Therapist. Given that hospital admission is a stage in the therapeutic process which is limited, and that the main part of this is going to come about in outpatient care, at the very least a telephone conversation with this professional is required during treatment, which would allow for the necessary continuity of the process and provide the outpatient clinician with the relevant information.

h. The Discharge. This should be brought about when the objectives initially set forth have been reached and when continuing treatment under minimally effective conditions is no longer possible. It is important that the patient and, if be the case, his relatives are aware of the reasons for the discharge and of the therapeutic steps to follow.

The fundamental consequence of the breach in the therapeutic commitment on the part of the patient should be the halting of the inpatient treatment and its eventual resumption only after a period of four months. The structure of our public network complicates the application of this principle. Some steps that could facilitate its application are the following:

1. The drafting of a list of patients who find themselves in that situation, so that all of the staff on call and at the inpatient unit has the list at their disposal.
2. If the patient demands inpatient admission, he or she should be reminded of the condition he or she is in, which should have already been clearly communicated to him or her the last time that the treatment was stopped. A clear refusal of admission must be stated.
3. Ranking of Alternatives to Inpatient Care
    a. Hours in the Emergency Department. Whenever it is possible. After having clear and concrete information that turns down the standard inpatient care for the above reasons, which the patient acknowledges, the patient is kept in emergency care until, within a few hours, the discharge becomes possible.
    b. 24/48 hours in emergency care. With the same ends if the above is not possible or sufficient.
    c. Admission to the unit, with very limited objectives, centred on diminishing distress, and discharge within 48/72 hours.

It is important to reiterate there are certain conditions in which safe and effective treatment of the patient is not possible. These measures hold the purpose of allowing the team and the therapist to find certain conditions that would make the clinical task possible again. Repeated entries into inpatient care imposed by the patient after voluntary discharges are of little use to the patient, bring about hospitalism, and lead to serious deterioration in the team morale and its therapeutic ability. The limitations of a public system are evident in this case, but inpatient care is a scant and valuable resource that we should protect. It is possible to structure inpatient care in an effective way and reduce the chances that the patient will destroy his or her therapeutic possibilities by expressing serious relational difficulties with the staff and others. Staff submission to abuse from the patient ruins the therapeutic options of the team for that patient as for all the others, and tends to be followed or complemented by punitive attitudes that in a somewhat concealed manner express rejection to the patient, culminating in the dismantling of the therapeutic process and bringing about very negative experiences for all involved.

The most recent studies on the effects of these pathologies paint a rosier picture than in the past. If we are able to limit the harm that the patient is able to do to him or herself, and if we can build even a slightly significant therapeutic alliance, it is quite possible that the symptomatic intensity will eventually go down until adaptation to a healthier lifestyle becomes possible. The keys to an adequate inpatient approach are not necessarily the implementation of sophisticated psychotherapeutic models, which are difficult to apply outside of academic & research environments, but rather are the presence of a team that is available, trained and cohesive, and which offers a secure and healthy therapeutic atmosphere in which the professionals' identification with the pathological roles in which the patient frequently attempts to place them is minimised.

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