Brief Admission for Patients with Self-Harm from the Perspective of Outpatient Healthcare Professionals

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Brief Admission for patients with self-harm from the perspective of outpatient healthcare professionals.
Running title: A qualitative descriptive interview study.

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ABSTRACT

The aim of the study was to describe the role of brief-admission (BA) in treating high-risk patients with self-harm from the perspective of outpatient healthcare staff in Sweden. Ten outpatient healthcare professionals from three psychiatric clinics were interviewed. Data were analyzed using a conventional content analysis.

The findings of this study help support the role of BA as an acute crisis management intervention, and describe how BA serves as a useful adjunct to outpatient treatment, especially for patients with complementarily psychotherapeutic interventions. The findings also suggest that implementing BA may increase treatment opportunities for outpatient staff and strengthen the concept of person-centered care.

Keywords: Acute Crisis management, Borderline personality disorder, Brief admission, Content analysis, Interviews, Outpatient staff, Self-harm, Qualitative descriptive research.
BACKGROUND

Self-harm is a term that is widely used within psychiatric care (de Klerk et al., 2011) and is mostly associated with inflicting physical self-injury such as cutting or burning the skin (Vahia, 2013; Klonsky, 2014). Depending on the severity of certain diagnoses, some patients have a higher risk of self-harming. One classic example of this includes Borderline Personality Disorder (BPD). BPD is characterized by a consistent pattern of instability in Cognition, affectivity, personal functioning and impulse control (American Psychiatric Association, 2013), often characterized by emotional instability along with self-harm (Tyrer et al., 2015). The general consensus is that self-harm and BPD are closely linked, and it is estimated that 65-80% of patients with BPD have engaged in some form of self-harm (Brickman et al., 2014).

A key component and first line treatment in outpatient settings for patients with BPD includes some form of psychological intervention, often dialectical behavior therapy (DBT) (Linehan, 2015; Miller et al., 2006). Alongside individual psychotherapy, a skills training group is provided where the patients learn a variety of skills, including core mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance (May et al., 2016). DBT is the only empirically supported treatment for BPD and compared to other forms of treatment it has been more effective in reducing parasuicidal behaviors and reducing the number of inpatient hospitalizations (Paris, 2010; May et al., 2016). Patients who self-harm can also be provided with other types of social and emotional support, for example suicide prevention programs, where weekly medicine distribution and outpatient appointments are also available. However, creating a treatment plan is not always simple, and the lack of treatment specificity is the rule rather than the exception (Skodol et al., 2010).
BPD is often presented with a range of symptoms and behaviors including pattern of unstable and intense interpersonal relationships where the person alternates between idealizing and devaluing people in their environment. In addition, people with BPD often have periods of anger, panic or despair and may suffer from feelings of abandonment that may provoke impulsive actions (American Psychiatric Association, 2013) along with an affective instability that often lasts from hours to days (Gurvits et al., 2000). All the above can be traced to the concept of an acute crisis. During such acute crisis, a patient may seek emergency psychiatric care; either prior to or after self-harm or impulsive actions (Paruk et al., 2016), which often ends with an admission to psychiatric inpatient care (Lundahl et al., 2018). The admissions often become long-lasting (Perseius et al., 2005) and involve coercive measures, compulsive medication, and constant supervision by staff (Lundahl et al., 2018). This may reduce the person’s own ability to handle acute crisis (Caroll et al., 2014; Liljedahl et al., 2017), which can result in increasing self-harm and surveillance (Perseius et al., 2003). Previous acute crisis interventions are often researched and evaluated after self-harm or suicidality (Warrender et al., 2021). However acute crisis interventions for management of patients with BPD is not well understood (Borschmann et al., 2012; Warrender et al., 2021). During acute crisis persons with BPD may frequently present to health services (Stoffers, 2010). The concept of Brief Admission (BA) was introduced in the 1990s, when hospitalization drastically rose and long admission for patients with BPD was found to have clearly negative consequences, including regression, increased “acting out” behavior (Hellemant et al., 2014; Helleman, 2017), and decreased autonomy and self-care (Perseius et al., 2005). Today some regions in Sweden provide BA as an optional and complementarily alternative to their ongoing outpatient treatment to use when, for example, they experience an acute crisis in order to decrease the number of long-term admissions and negative consequences, and to encourage autonomy in patients (Eckerström et al., 2020). If BA is requested, a patient signs an agreement involving themselves, their
responsible outpatient healthcare provider and a responsible nurse from the inpatient clinic (Helleman, 2017). As part of the agreement, through self-referral, a patient calls the inpatient clinic and requests hospitalization. Assuming there is an admission spot available, the patient can admit themselves for a period of one to five days.

Previous research concerning BA for persons with BPD has mainly focused on patients’ experiences of BA (Eckerström et al., 2020: Helleman et al., 2018b: Lindkvist et al., 2021). BA has been found to be a worthy alternative to losing control, facing rejection, or having life interrupted in times of crisis among persons with severe self-harm (Lindkvist et al., 2021), while allowing the patient to be in a safe environment with inpatient staff using crisis techniques and routines to cope with impulsive behavior (Eckerström et al., 2019). Previous research further highlights that patients with severe mental illness signing a contract for BA coped longer than those receiving usual care (Rise et al., 2014), and the number of days in regular inpatient care, the number of days of compulsory care and actions of self-harm decreased (Ellegaard et al., 2020: Westling et al., 2019). Furthermore, BA has been shown to teach patients to live more independently and to reduce self-harm outside the ward (Mortimer-Jones et al., 2019). Among inpatient nurses, BA seemed to reduce work-related stress experienced while caring for persons with BPD and self-harm, and supported nurses in their ability to provide more meaningful and constructive psychiatric inpatient care (Eckerström et al., 2019). To our knowledge, research assessing BA from an outpatient healthcare staff perspective has not previously been performed. The aim of the study was to describe the role of BA in treating high-risk patients with self-harm from the perspective of outpatient healthcare staff.

METHODS
A qualitative, descriptive study design aims to illuminate and describe events in everyday life as close to the participants’ own words and descriptions as possible (Sandelowski, 2000). This design was considered appropriate as it provides new insights and increases the researcher’s understanding of a particular phenomenon (Patton, 2015).

Setting and participants:

Participants were recruited from a region consisting of three separate outpatient psychiatric clinics that worked in collaboration with their respective inpatient psychiatric clinics to implement BA for patients with self-harm. Each individual clinic implemented BA according to the same guidelines and regulations. When approval had been received from healthcare managers, a list of eligible outpatient staff was obtained by speaking with the head outpatient staff member in charge of BA implementation in the region. This person provided names of those who worked with patients who had signed BA contracts. The potential participants were contacted by phone and everyone who was asked wanted to participate in the study. The inclusion criteria included that the staff needed to have been directly involved in constructing the BA agreement with their patient. Each outpatient healthcare staff member was also required to have been partially responsible for or a main provider of their patient’s outpatient treatment. A total of ten interviews with outpatient staff were conducted, with at least one interview obtained from each clinic. (See table 1).

Please insert table 1 here

Data collection and analysis:
Qualitative semi-structured interviews were considered useful as they gave the participants the opportunity to respond in their own words and to express their own personal experiences but within a given frame (Patton, 2015). The interviews took place in the participants’ workplace, in secluded rooms. Before each interview began, all participants gave written informed consent and background information was obtained. The semi-structured interview guide used consisted of six open-ended questions covering the main theme of assessing the role of BA from an outpatient staff perspective. The questions were structured to obtain the perspectives of outpatient staff, and during the interview, each staff member was encouraged to freely express their experience of adopting BA as a complement to ongoing outpatient treatment. Some examples of question areas were: Can you tell me how the BA agreement has worked for your patients? How well have you been able to relate to the BA concept? How have you experienced the patients' mental health after they entered the BA contract? The interviews were conducted by the first author (A.A) with experience of working with self-harm in an inpatient psychiatric ward; however, without previous working relationships within the interviewed outpatient clinics. Two test interviews (included in the study) were carried out, leading to minor revisions of the interview guide. The interviews took place in October 2019 and lasted between 20 and 65 minutes. The time and place were selected according to availability in the staff schedules. The interviews were audio-recorded and transcribed verbatim (MacLean et al., 2004).

For data analysis, conventional content analysis was used in accordance with Hsieh and Shannon, (2005). In order to increase the accuracy of the transcriptions, the recordings were compared to the original transcriptions. The verbatim transcriptions were read repeatedly to obtain a general overview and a deeper comprehension of the text. The transcripts were then read word by word to find and highlight exact words in the text that captured key thoughts or concepts related to the aim. In this process, codes were labeled as close to the original text as
possible, and if found to be relevant to the aim, grouped first into subcategories and then main
categories, based on how they were related and linked. As a final step, excerpts of the raw data
were read to validate the content of the categories (Patton, 2015). The categories and their
names were derived from data and not from preconceived categories, a procedure known as
inductive category development (Kondracki & Wellman, 2002).

Ethical considerations:

The research application, Dnr 2018/260-31, was approved by the Ethical Review Board in
Linköping, Sweden. The ethical standards of the World Medical Association’s Declaration of
Helsinki (2013) were followed. The research process and how the method and results were
followed the consolidated criteria for reporting qualitative research followed the COREQ
guidelines (Tong et al., 2007).

RESULTS:

The results were grouped into three main categories, presented in a sort of hierarchical structure
explained in a figure that illustrates the role of BA from an outpatient staff perspective (Figure
1). This figure describes how the main categories, direct and indirect adjuncts to outpatient
treatment, work in unison to aid outpatient staff in treating high-risk patients with self-harm
and simultaneously address specific BA components that outpatient staff deemed essential to
achieve this. The results indicate that the effect BA had in aiding outpatient staff depended
highly on which outpatient treatment was provided to an individual patient. Although patients
often had simultaneous forms of treatment such as pharmacotherapy, the major difference
between the types of outpatient treatment provided by the 10 interviewed staff involved psychotherapeutic interventions versus suicide-preventative treatment with no psychotherapy.

*Figure 1 in here*

**DIRECT ADJUNCT TO OUTPATIENT TREATMENT**

The first main category, direct adjunct to outpatient treatment, suggest that outpatient staffs descriptions of BA could be utilized as an acute crisis management system alone or as an acute crisis management system used complementarily with psychotherapy.

**Acute crisis management**

The outpatient staff found that BA helped their patients to manage acute crisis by directly preventing maladaptive behavior such as self-harm. The outpatient staff found that BA inhibited maladaptive impulses that patients had been accustomed to experiencing in the past, and also aided in lowering patient’s anxiety levels. Staff recognized a substantial decrease in the frequency of self-harm among their patients, even in the presence of chronic suicidal thoughts.

Outpatient staff also said that BA was utilized as a suicide-prevention tool for some patients, especially for patients with a severe degree of emotional lability. For some patients, outpatient staff said that BA was used interchangeably for both preventing maladaptive behavior and as a suicide-prevention tool. Although BA was described to be helpful to patients in actualizing admission, outpatient staff said that the action of making the phone call to the inpatient ward and asking for admission was beneficial as well. Outpatient staff said that by taking action and making the phone call on their own, patients experienced a reduced amount of anxiety and this helped them break destructive thought patterns.
“I think that she has used it 10 times to date and it is been during times of increased suicidal thoughts, increased thoughts of inflicting self-harm, and risk of intoxication, and instead of doing this, to break these destructive patterns, the patient instead was able to call the inpatient ward for support (9).”

The results suggest that BA could provide patients with an opportunity to assess their own emotional state during a crisis. The first step is to assess the severity of the crisis and emotional state, the second is to make the call, and the third is to admit themselves to the inpatient ward.

**Complementary to psychotherapy**

The outpatient staffs’ perspective on BA differed depending on whether BA was used as an acute crisis management system alone or used complementary to psychotherapy. The results support the view that BA as an alternative crisis management intervention serves as a direct adjunct to outpatient treatment but highlight the need for complementary psychotherapy to achieve stable and durable treatment. Although BA as an acute crisis management system serves a purpose, BA used complementarily with psychotherapy is essential to successfully treat these patients.

“The patient experiences a great effect from having BA available, but I think that DBT plays a large part therapeutically, to gain tools, concrete tools to manage their anxiety before they self-harm (1).”

For outpatient staff who provide psychotherapy as part of outpatient treatment, BA was found to increase participation levels during psychotherapy. One outpatient staff member suggested
that because psychotherapy can sometimes cause increased levels of anxiety and emotional distress for patients, BA in outpatient staff’s opinion, is perceived as an extension of outpatient treatment.

“The patient has dared a little more during DBT and learned to trust her own ability to manage herself, not only trust in their pharmacotherapy and Electro compulsive treatment like previously. It has helped the patient participate in DBT, and provided courage to go to therapy and expose herself to trauma, which she did not dare to do before (5).”

Another way BA seems to complement psychotherapy is that it coincides with key components taught in therapy including permitting patients to gain positive experiences of utilizing psychiatric healthcare, thereby increasing interpersonal effectiveness. In psychotherapy, the term ‘interpersonal effectiveness’ is used to describe the ability to communicate or ask for things in a thoughtful manner. Patients are also encouraged to accept their level of emotional dysfunction and through the process of self-referral, patients practice this skill. Because most patients utilizing BA have a long medical history of self-harm and compulsory inpatient admissions, the outpatient staff believe that BA, as part of outpatient treatment, can provide patients with a way to create new conditions to practice interpersonal effectiveness. Emotion regulation can also be achieved if BA is used alongside psychotherapy. Emotion regulation comprises pursuing healthy habits to make patients less vulnerable to their emotional dysregulation and includes acquiring balanced eating patterns, balanced sleep routines and an adequate amount of exercise, all of which can be achieved during BA.
“My patient works night shifts and has difficulty getting enough sleep. She works hard during the weekdays so she often uses BA on weekends when she hasn’t received enough social support because she is constantly active during the weekdays... she uses it to catch her breath, get some sleep and feel safe (3).”

INDIRECT ADJUNCT TO OUTPATIENT TREATMENT

The second main category, indirect adjunct to outpatient treatment, demonstrates how outpatient staffs descriptions of BA indirectly complements outpatient treatment and increases their patient’s autonomy, which in turn creates interpersonal effectiveness, and motivates patients to live a quality functional life. The outpatient staff reported that BA provides a safe environment for their patients to use during a crisis and that BA also provides security for them.

Autonomy and responsibility

The results support the view that BA indirectly provides autonomy for patients. This was suggested because in order for a patient to utilize BA through self-referral, the patient has to first establish that they are in an acute crisis and assess their emotional state. This supports outpatient treatment because psychotherapy encourages patients to take responsibility with the hope of gaining a level of awareness and independence.

“...again what is in line with DBT is “I am responsible for my own health, that healthcare is here to help me, but at the end it is up to myself to change and clearly mark that I have now done something different, I asked for help and hopefully received it (9).”
Throughout DBT, patients are taught enough life skills to cope with their emotional dysregulation in an independent and constructive way. The transition to independence seems to be difficult for some patients. According to the outpatient staff, during this transition BA can help to also achieve autonomy.

“This patient completed DBT and it was on the same day we completed DBT, in the afternoon, that she contacted the inpatient ward, because from what I understood she felt insecure, unsafe and that she would no longer have contact with me or DBT…she then experienced increased maladaptive impulses, she had had these urges sometime before and I considered that there was a clear reason why these had increased, but she managed it, just like I thought she would. The difference was that she now had psychotherapeutic tools to apply (2).”

Security for staff and patients

The outpatient staff said that BA provided security for their patients, independent of whether the patient had utilized BA or not. Because BA includes weekends and evening hours, BA provides extended access to treatment compared to regular outpatient clinic hours. This increased access to treatment is suggested by the outpatient staff to play a large part in providing security to patients. When a patient experiences emotions such as fear and impulsivity during an acute crisis, the patient is encouraged to perform several activities on a so-called crisis list. If, however, the crisis list is found to be insufficient, BA can provide security. A large part of outpatient treatment is to teach patients that they are in control of their emotions, and in psychotherapy, skills are taught to cope with external challenges such as invalidating environments. The outpatient staff described how BA provides a respite or break from
environmental triggers and provides a secure and helpful environment to cope with their emotional dysregulation.

“To catch their breath in a different environment, an environment that is safe, clear and structured but also an environment where their family is not present, will be helpful(4).”

The results suggest that BA not only provides security for patients but also for outpatient staff, who from an outpatient perspective, could indirectly achieve more effective outpatient treatment. One outpatient staff member for example, emphasized that BA provided comfort because he/she was new within his/her profession and had little experience of patients who self-harm.

“It provides security for me that if that my patient feels unstable over the weekend, that she could use it then (7)”. 

Besides providing security for patients and for the outpatient staff treating these patients, BA was also suggested to provide continuity during outpatient treatment. Outpatient staff described compulsory inpatient admissions as counterproductive and welcomed the fact that BA provided a solution for receiving inpatient care when needed, but not at the expense of disrupting outpatient treatment.

Integrative approach

A goal of outpatient treatment is for an individual to transition from being a patient to becoming a person with the ability to manage and live a good quality of life. The results of this study
suggest that BA can enhance quality of life for some patients by focusing on an integrative approach, and by doing so indirectly strengthening outpatient treatment. Outpatient staff said that BA created a more positive attitude from psychiatric care toward patients and also that their patients felt an increased amount of moral support as a result of increased cooperation between inpatient and outpatient settings. The outpatient staff also emphasized the importance of knowing their patients’ preferences and of seeing the individual for who they were, beyond their diagnosis and impulsive actions.

“I believe it becomes more person-centered care. For example, we have set out activities to do during Brief Admission like listen to music, have a conversation with staff, relaxing activities such as yoga, weighted blanket…It’s good that this is in the agreement so that everyone knows what to do and how to help the patient(10)”.

Outpatient staff described how patients with low self-esteem often feel like a burden to themselves, healthcare, family, and friends. To strengthen a patients’ identity is an essential aspect of outpatient treatment and the outpatient staff suggested that BA achieves this. Helping to increase the individual social and spiritual aspects of a patient is interpreted as an integrative approach to patient care that could also indirectly strengthen outpatient treatment.

“My patient does not want to be a burden, she does not feel she is worth the trouble of having a friend sit and listen to her concerns for example, and this is a huge problem. BA relieves her feelings that she is burdening her friends, so that she can instead utilize the healthcare (1).”
IMPACT OF BA COMPONENTS

The last main category, impact of BA components, emphasizes that outpatient staff's descriptions was in order for BA to function as a direct and indirect adjunct to outpatient treatment, optimization of certain BA components is required. The outpatient staff highlighted three BA components found specifically to have had an impact on implementing BA with their patients, and stressed that these are essential in order for their patients to trust in BA. These included past experiences of inpatient care, psychiatric resources, and individual utilization.

Past experiences of inpatient care

Involuntary psychiatric treatment and restraints provided in inpatient settings, although necessary in severe circumstances, present challenges for outpatient staff. Outpatient staff emphasized that some patients were even traumatized after previous compulsory admissions and that these past experiences needed to be addressed during outpatient treatment. Patients with negative past experiences were experienced by outpatient staff to be reluctant to utilize BA. Outpatient staff said that approaching past experiences in therapy was necessary before their patient felt comfortable using BA.

“My patient has a history of compulsory admission and involuntary belt restraints, and when the patient tried to commit suicide the staff had to wrestle the patient, five staff members had to hold her down, and this event still gives her nightmares and flashbacks, something that is very difficult and she is still affected by today (5).”
One outpatient staff member reported that even the stigmatism around inpatient care inhibited her patient from using BA.

“There are many thoughts and speculations concerning what mental illness is and how/what inpatient care encompasses (6).”

Acknowledging the impact of past experiences could provide outpatient staff with guidance in deciding when to implement BA. The results suggest that a certain amount of psychotherapy and time within outpatient settings is required before BA will have any useful effect.

**Psychiatric resources**

The two main resources described by outpatient staff to impact trustworthiness and the effects of BA are the accessibility of staff and the accessibility of care or admission spots. The results emphasize that outpatient staff responsible for initiating BA with their patients need to feel comfortable doing so and should have a clear vision of how to relate to BA and of the role BA could provide for their patient. When the patients and the outpatient staff sign the BA agreement with the inpatient staff, they decide what the patient should do if there are no admission spots available during their time of crisis. This could include either using more psychotherapeutic tools or if the crisis is severe, seeking regular general admission. The outpatient staff stressed that in order for BA to provide any true purpose or functioning role, the number of times patients are denied admission spots due to limited resources needs to decrease. Several outpatient staff members said that limiting admission spots not only decreases the trustworthiness of BA as an acute crisis intervention from the perspective of the patient but also from their own perspective.
“I am uncertain if we can have more than 3-4 BA agreements in total in circumstances when the ward is full, which in turn undermines the concept as a whole if the patient never succeeds in applying for BA. I believe that there need to be more admission spots available, clearer information and more presence from staff in the course of treatment (4).”

Individualistic utilization

A controversial topic mentioned by the outpatient staff concerned how to use BA in a constructive and effective way with their patients. Outpatient staff said it was difficult not to recommend or encourage patients in crisis to utilize BA because this would undermine the patients’ autonomy. One outpatient staff member said that inpatient and outpatient colleagues would seek BA implementation with urgency during times of crisis and emphasized that important decisions such as implementing BA cannot be made properly by staff or patients in such periods. The outpatient staff expressed difficulty in helping their patients decide when to seek regular admission rather than seek BA.

“They use BA when it is hard to manage emotions, when they need more protection around them. But if they need to seek regular admission it is because they are incapable of using their therapeutic skills, their urge to inflict self-harm and feel that “I cannot handle this, I am actually scared I will commit suicide” – then they can assess they need more help(10).”
The results support the view that utilization of BA is highly individualistic. What is defined in the BA agreement and how it is constructed among inpatient and outpatient staff and the patient determines when BA should be used rather than regular admission. The outpatient staff said that in spite of occasional confusion, being able to individualize BA was beneficial, and to achieve a more effective use of BA, revised knowledge and careful thought should be applied when constructing the agreement.

**DISCUSSION**

The findings of this study suggest that BA, because of its broad purpose and implementation approach, has created opportunities for the outpatient staff to use BA in the way they deem necessary. BA aided outpatient staff directly in treating patients who self-harm in two ways, as an acute crisis management or as an acute crisis management complementary to outpatient psychotherapy. As an acute crisis management, BA was described as decreasing self-harm. Outpatient staff described how BA could help them to conduct a chain analysis with their patients and provided an opportunity for patients to exchange their maladaptive or suicidal behavior by instead admitting themselves via BA as a new coping skill. Chain analysis focuses on sequential events that allow the patient to understand their own behavioral patterns, what their behavioral patterns are caused by and what consequences could follow such patterns, Linehan (2015). After conducting such an analysis, the patients are encouraged to try to apply a new skillful behavior to replace their old problematic ones with (Fassbinder et al., 2016).

Outpatient staff described how outpatient treatment prioritizes ways to increase a patients’ autonomy, which supports the reasoning concerning why the BA agreement should be developed with their patient. For some patients who have a difficult time communicating thoughts and emotions, help from outpatient staff to establish the terms of the BA agreement is needed. One important aspect of BA is that a BA plan or agreement should be developed with
the patient (Helleman et al., 2018a). Although outpatient staff described certain difficulties in relating to BA objectively, in spite of this they suggested that BA created an additional opportunity for them to increase a patient’s autonomy and more specifically participation in outpatient treatment. Previous research shows that patients experienced relief and liberation when trusted to be in charge of their care, which contributed to individual development of autonomy (Lindkvist et al., 2021). Thus, BA can provide a structured and secure environment with the opportunity for short-term recovery. Outpatient staff emphasized that BA indirectly allowed for enhanced continuity in outpatient treatment and offered patients and staff an opportunity to avoid the risk of long and compulsory admissions. Moreover, if a patient was admitted via BA and they had a simultaneous outpatient appointment, nothing prevented them from attending that appointment. The finding that BA provides a level of continuity and security supports previous research suggesting ways in which, from inpatient nurse perspectives, BA could aid treat patients with emotional instability (Eckerström et al., 2019). Patients with BPD are easily affected by their surroundings and experience difficulty establishing quality relationships; it is common for these patients to characterize their social interactions as disagreeable and empty (Stepp et al., 2009; American Psychiatric Association, 2013). The findings of this study support previous research advocating that treating BPD patients through a team approach is promising and should be done by developing a shared understanding of each patient’s needs and a support plan (Lindkvist et al., 2021; Dean et al., 2018). The findings also support research stating that the benefits of BA include a supportive team approach and the flexibility of staff to care for their patients (Mortimer-Jones et al., 2019). It became apparent that those outpatient staff who were more flexible and engaged in constructing BA as a successful tool for their patients had more positive experiences of implementing BA. Repeated staff education during BA implementation has proved to be important (Helleman et al., 2018a). Previous research describing patients’ experiences of BA and reasons for not requesting it was
found to include fear of rejection, a presumed room shortage, and deciding if their crisis or emotional state was severe enough (Helleman et al., 2018b). The outpatient staff consistently emphasized the importance of incorporating a modern integrative approach in the hope that decreasing negative experiences of past compulsory admissions would enhance patients’ trust in psychiatric care provided in outpatient settings. The results of this study showed that BA often induced positive attitudes in psychiatric staff and patients, which is supported by previous research (Eckerström et al., 2019: Eckerström et al., 2020). This altered positive attitude, empowering the person, promotes person-centered care. Although previous research suggests that BA may support inpatient nurses in their ability to provide more meaningful and constructive care (Eckerström et al., 2019) the same is suggested for outpatient staff. The importance of a non-judgmental attitude from staff to increase the autonomy and independence of the patients, are fulfilled more likely when the patient request BA independently (Helleman et al., 2018b) Although the findings of this study suggest that outpatient staff must sometimes encourage their patients to utilize BA, future studies should research to what extent and whether doing so diminishes autonomy.

The method used to analyze data in this study was conventional content analysis (Hsieh & Shannon 2005). The strengths of this direct approach include that existing theories can be supported and extended, especially in areas where research may grow. Because there is pre-existing research on BA, the findings of this study can be viewed as a complement to this pre-existing research. Most qualitative research describing experiences of adopting BA, has been conducted from a patient and inpatient staff perspective (Helleman, 2017: Eckerström et al., 2020). This is one of the first studies to our knowledge that focuses on assessing the role of BA from an outpatient staff perspective. This is a strength of this study as it aims to describe a phenomenon that has so far seen limited research (Hsieh & Shannon, 2005). When conducting a conventional content analysis, Hsieh and Shannon (2005) state that there is a risk that authors
may not understand the context in full and therefore may fail to identify key categories. However, in this case the authors were psychiatric nurses and a medical student, with experience of working and researching within the psychiatric field.

Trustworthiness in qualitative descriptive research is based on how well the themes cover what the participants said (Polit & Beck, 2017). To strengthen the credibility of the results, the categories were presented with quotes. The two co-authors (S.H & R.W), who are trained in qualitative content analysis, evaluated the data analysis to confirm its relevance, which enhances the credibility of the study, Patton (2015). In the analysis process, internal validity was ensured via peer debriefing (Hsieh & Shannon, 2005), which involved all authors agreeing on the development of categories in order to strengthen the trustworthiness of the results.

Because this study considers experiences of adopting BA and assesses the role of BA from an outpatient perspective, the study’s findings can serve as a guide for future outpatient staff or clinics considering implementing BA. Purposeful sampling, which included identifying and selecting an optimal group of outpatient staff participants, helped retrieve rich information assessing BA from an outpatient perspective (Patton, 2015; Palinkas et al., 2015). As no new data appeared in the last interviews, the data can be considered saturated. Based on the broad range of backgrounds and demographics of the participants and the rich data collected, we would argue that our sample includes a sufficient range of participants (Patton, 2015). Although useful insights obtained in this study can be used for future contexts and other outpatient clinics, the transferability of the results of this study is questionable because of the highly selected group of interviewee participants. The results of this study consist mainly of positive reflections on adopting BA described by outpatient staff. It is important to consider that the results and data collected from the interviews could be biased because the outpatient staff themselves are responsible for providing outpatient treatment. The outpatient staff could be evaluating the role
of BA in a manner that is consistent with pre-existing beliefs, resulting in confirmation bias (Allahverdyan & Galstyan, 2014).

CONCLUSIONS

The results of this study indicate that BA can be used both as a direct and indirect adjunct to outpatient treatment. As an acute management intervention BA could potentially replace self-harm as a problem-solving strategy for patients. The findings also suggest that utilizing BA as an acute crisis management system complementarily with outpatient treatment in the form of psychotherapy could result in more effective and durable outcomes. Irrespective of how BA is used, whether only as an acute crisis management system or in conjunction with psychotherapy, or whether it is assessed as either a direct or indirect adjunct to different outpatient treatment, the findings of this study support the view that BA plays an important role as an adjunct to outpatient treatment from the perspective of outpatient staff.

RELEVANCE FOR CLINICAL PRACTICE

Outpatient staff highlighted the effect that BA had on patients with self-harm, when BA was used as an acute crisis intervention complementarily with outpatient treatment such as psychotherapy. The findings of this study could consider complementary psychotherapy as a possible inclusion criterion for patients eligible for BA in future research. This study’s findings may also provide other useful insights for other outpatient staff or clinics considering implementing BA in their psychiatric outpatient clinics. Although the findings of this study
incorporate a rather detailed assessment of BA from an outpatient staff perspective, more research is needed to understand the role that BA provides as an adjunct to psychotherapy.

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