

The SUN Project: Open Access Community-Based Support Groups for People with Personality Disorder

Description of the Service Model and Theoretical Foundations

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ABSTRACT: Previous investigations into concerns that people with a personality disorder (PD) may be excluded from treatment revealed that one quarter of Mental Health Trusts provided no service for this patient group (NIMHE (National Institute for Mental Health in England), 2003). It subsequently became a recommendation by the Department of Health (DH) that mental health trusts in England and Wales provide such services. In line with this recommendation the DH commissioned 11 new PD treatment services in England, without specifying the model of service to be used. This lack of specification was in recognition of the open state of the theoretical and evidence base for treatment of PD. In 2004, the Service User Network (SUN Project) was funded as one of these pilot services. The Sun Project adopts the ethos of the therapeutic community and draws upon cognitive theories and psychoanalytic understanding of PD. People who use it have been involved in the design, development and implementation of the service. This paper describes the replicable service model for community-based open access support groups for people with PD, and its theoretical underpinnings.

Introduction

In 2004 the SUN Project (Service User Network) was funded by the Department of Health (DH) to pilot a support service for people with personality disorder (PD) in South West London. The pilot aimed to improve access to services, increase empowerment, improve coping and reduce emergency service use. The target

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population was to be those patients excluded from other services, including those for whom specific treatments had been ineffective. In 2009 the service was replicated in a neighbouring London borough.

Defining the target population for an inclusive service was a key issue to be negotiated in the design stages of the project. Traditional approaches such as selecting individuals by diagnosis and predicted response to treatment are potentially problematic for several reasons. Specifying a particular diagnosis is too narrow an approach, as the diagnosis of PD covers a wide range of conditions, with disparate presentations and overlap between classifications. Individuals often satisfy criteria for multiple diagnoses (Dolan, Warren & Norton, 1997). Moreover, potential referrers are often reluctant to diagnose PD and, if made, the diagnosis is frequently withheld from the patient (Clafferty, McCabe & Brown, 2001). In addition some people who have been given the diagnosis do not view this as legitimate and do not wish to be labelled as such (Barlow, Miller & Norton, 2007).

Utilising 'treatability' as a selection criterion for entry into the service was equally unsuited to meet our aims as PD is a chronic condition and, although treatment outcomes are becoming increasingly more favourable, some individuals do not respond to treatment. Moreover, prediction of those who will respond is inaccurate (McMurrin, Huband & Overton, 2010), with reported dropout rates differing between treatments and ranging between 23% and 50% (Crawford et al., 2009; Giesen-Bloo et al., 2006). Furthermore, decisions about diagnosis and treatability tend to be determined by health care professionals, whereas the aim of the project was to promote self-determination and empowerment.

The SUN model therefore allows service-users themselves, with or without a diagnosis of PD, to decide whether they access the service, when they leave it, and to accommodate those whose problems remain ongoing. To further improve access, and reduce stigma, services are offered in local community settings.

How the SUN model meets the challenges of a community-delivered open access support service for people with PD is described below.

The SUN Project model

All aspects of the SUN Project support are delivered in community-based groups. There exists no individual contact with any of the service users. The services (the original, together with the replicated service) are organised by geographical area such that four groups, each meeting a minimum of four times a week, offer a service for a total catchment area of 1.35 million people. The total membership of the combined services is over 500 people, and membership of each group varies according to who attends on the day. An average group will have ten service users present.

Staffing

Groups are facilitated by a combination of health care professionals, ex-service users, and current service users. Service users are trained to participate in the

SUN Project. Regular teaching sessions are offered as part of groups and people are asked to take active roles in running groups, participating in management committees and educational events. Within the original model, roles have been created for lead service users (termed 'volunteer facilitators') together with specific paid roles existing for ex-SUN members to work within the team as support facilitators. The replicated service offers volunteer facilitator training, in the spirit of promoting empowerment, but without paid roles.

Staff facilitators possess a recognised health care qualification and are experienced in multiple aspects of mental health. Their role is to make sure that groups start and finish on time, to facilitate the group model and link with other parts of the health care system, particularly in the event of crises and emergencies. A consultant psychiatrist operates as the clinical team leader in both the original and replicated services.

Engagement and empowerment

Fundamental to creating empowerment and engagement in the SUN Project is the therapeutic community (TC) principle that the effectiveness of the service depends upon engaging service users in the task of creating, running and delivering it.

A service user was involved in the design of the initial service specification and later became a member of the interview panel when staff members were recruited. All subsequent recruitments have also included service users in the appointment panels. In the early stages of the SUN Project, service users worked in partnership with staff to design the publicity material that defined the entry criteria to the service. These criteria were based on SUN members' experiences of living with personality difficulties and framed in terms that are readily understandable to other service users. Service user involvement at this early stage of development affords the potential for members to engage creatively and meaningfully within a developmental process, as opposed to feeling that a service is imposed upon them. For the same reason, the culture of the model includes an emphasis upon a 'partnership' between staff and members. The therapeutic merit of this approach has been described fully in a previous paper (Jones & Miller, 2011).

Accessing the service

Only self-referrals are accepted and all people who consider our publicity relevant to them are given the opportunity to access the service. No assessment of the individual is made and no-one is excluded. This open access nature of the SUN Project requires careful attention to risk management and the provision of a safe working environment. We compensate for the unpredictability of the day-to-day membership of the groups by highly structuring the supportive model for all SUN groups (see below).

On initial contact by telephone the prospective group member is given an invitation to the next available group. At first group attendance it is the task of

established group members to be welcoming, share their experiences of the SUN Project and answer questions. It is made explicit in the groups that the group members themselves represent a resource for present support and that the staff facilitators' role is to create and maintain a method of interacting that enables service users to support each other.

At a person's second attendance a Crisis and Support Plan (CASP) is developed jointly with other group members. The CASP identifies what problems challenge the individual, and safer and more helpful ways of coping are identified by the group. Completing a CASP provides practical steps, constitutes a risk assessment, and identifies thoughts and behaviours for modification (Seller & Miller, 2006).

Structure of SUN activities

A. Three-part SUN groups, *the basis of the service:*

Every SUN group runs for 2½ hours and is divided into three parts: 'check-in', main part, and 'check-out', each separated by short breaks. The check-in is highly structured, the task of the group being to ensure that every person in attendance voices their current state of mind and wellbeing. This then sets the agenda for that day. The middle part of the group then attends to the issues that have been raised in check-in. This takes the form of emotional support, dealing with practical matters, attending to CASPs and welcoming new members. However, given the content of our groups and the nature of the people that we are attempting to help, it is not safe to assume that a person who began the group in a good state of mind remains that way at the end. The third part of the group, the check-out, therefore checks the states of mind of the group members at the end of the group, makes plans for the safe return to the next group, and deals with any emergencies that have been made manifest. At the end of the group a service user is tasked to minute the group, using a semi-structured format. This is the only routine record that is made. When emergencies occur, staff members may additionally make entries in the separate hospital records.

B. Other group activities:

The groups, with the provision of a staff facilitator, arrange social activities. Whilst the nature of some activities vary (from an outing to a park to meeting for a coffee, for example), some activities are set, such as constructing the monthly newsletter for members. Within the original service, a regular Art Group is also held, whilst in the replicated model a pottery group is run. These activities, stemming from but extending beyond the SUN group itself, help to attend to the difficulty in inter-personal relating so often encountered in people suffering from personality difficulties. They do not follow the three-part structure of SUN groups, but the presence of a facilitator helps redress inherent anxieties around inter-personal relating.

Along similar lines as described by Higgins (1997) SUN members can also offer to support one another out of hours using an 'on call' system. Members opt to be 'on call' in pairs, each then being given a designated mobile phone together with a written risk protocol. For any member wishing to be on call, a group consensus must be reached that the individual is well enough to undertake this duty.

C. Clinical supervision and training:

At the main weekly team meeting all the written group records made by the service users together with a verbal account of all the groups given by staff are discussed in detail. A consensus is then reached on the clinical direction that needs to be taken and this is written into the record to be read out in subsequent groups. This iterative approach is designed to share the ownership of the written record. Where a consensus cannot be reached, the lead clinician takes responsibility for the clinical direction. In times of crisis and increased risk this may take the form of a directive to act in a more certain manner. When negotiated well, the risk of the group being imposed upon by professionals is avoided, whilst still offering a containing function to further thinking. It is more usual, however, that the clinical direction takes the form of a suggestion for the group to think further about, such that the group processes themselves may be supportive. Careful attention is given to the significance of the impact on staff of working with PD and each staff member also receives supervision, support and training through the provision of three further weekly timetabled meetings. Practical issues pertaining to the logistics of planning and running of the service, psychodynamic understanding of the group processes, and training issues are dealt with here.

Theoretical foundations of the SUN model:

The SUN model integrates coping process modification, TC principles, and a psychoanalytic epistemology to create a coherent model of practice. The focus of the intervention is on the modification of processes in the present day rather than an exploration of difficulties in relation to early experiences.

Coping process theory:

Coping is defined as the ongoing effort to manage threats to one's psychological integrity (Lazarus, 1993). It involves a process whereby an individual possesses a repertoire of strategies that can be employed in a flexible manner. It is context dependent and will vary depending on the stressors placed upon the individual. Appraisal is the first step in a coping response (Croyle, 1992). Appraisal can be divided into primary appraisal, which may be quantified as the degree to which the subject believes that he or she is threatened by the event, and secondary appraisal, which is the subjective estimate of the resources available to cope with the threat.

Coping responses can be divided into problem-focused strategies and emotion-focused strategies. Problem-focused strategies involve taking action and include behaviours. Emotion-focused strategies can be understood using psychoanalytic theory. When stressful conditions are refractory to change, emotion-focused coping predominates.

Coping outcomes have in turn been divided into primary and secondary outcomes (Aldwin & Revenson, 1987). Primary outcomes are measures of coping efficacy, which is the success or otherwise of the psychological process in increasing the subjects' feeling of wellbeing. Secondary outcomes are measures of coping effectiveness, which is the relationship between coping and some outcome measure such as changes in health. At the most successful, an individual's coping responses increase both coping effectiveness, operating upon the external world to solve the source of the stress, and coping efficacy, reducing the amount of distress experienced and increasing the feeling of mastery and control over the event.

Figure 1: Steps involved in a coping response (after Parle & Maguire, 1995)

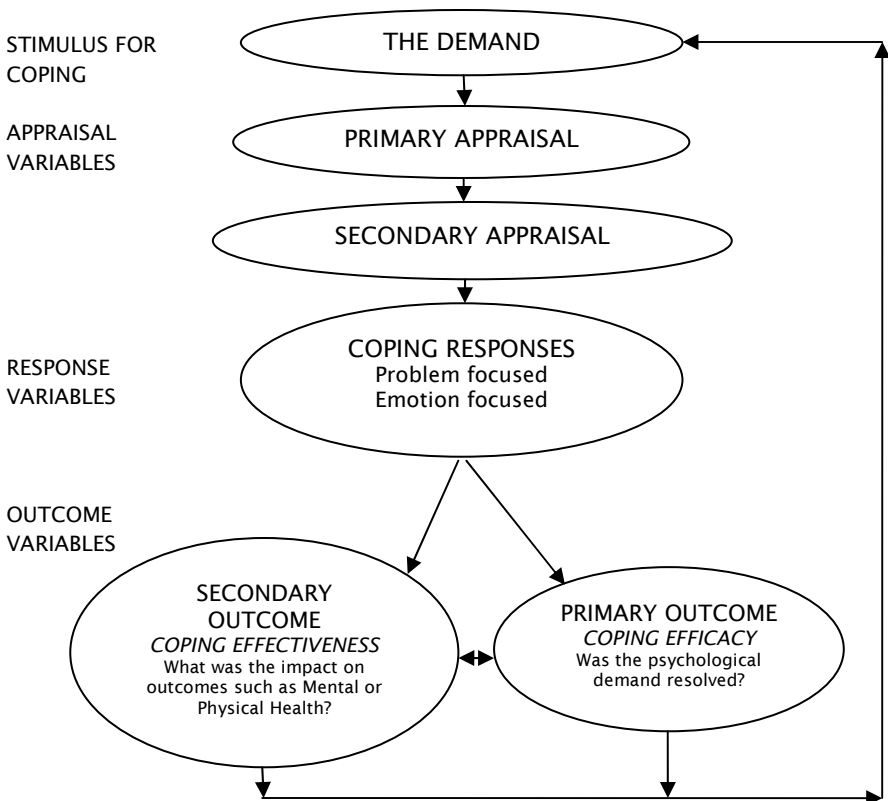


Figure 1 illustrates how the outcome of a coping response influences appraisal. From the diagram above it can be seen that the feedback loop has the potential to be positive (or negative) and modification of the steps in the process provides the opportunity for intervention.

Figure 2: Use of coping process theory to inform technique in a SUN three-part group

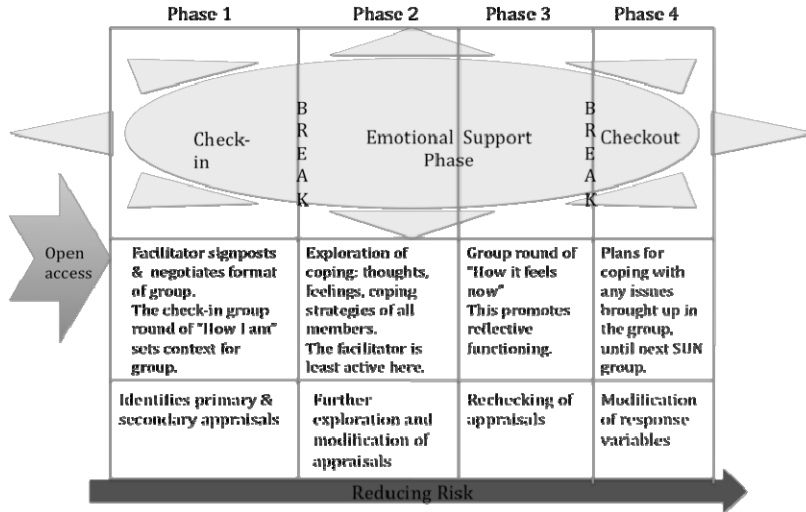


Figure 2 illustrates how coping theory is utilised to inform technique within the structure of a SUN three-part group.

To demonstrate how this process may be applied to an individual with PD in a SUN group, it is useful to examine a typical example of a crisis:

Following an argument, as has happened several times in the past; a person's partner leaves the family home declaring never to return. The individual left behind thinks this is permanent and declares to himself or herself 'I don't need anyone anyway. Good riddance ...' He or she then drinks alcohol in order to feel less angry and distressed: this is unsuccessful and feelings worsen. The individual now takes an overdose of paracetamol and telephones a friend to say 'goodbye'. The friend then telephones an ambulance. After six hours in the Accident and Emergency department of the local hospital, the individual returns home where their partner is waiting.

In terms of the coping process theory, the primary appraisal of the threat here posed by the partner leaving was very large and by contrast the secondary appraisal of the resources to cope was very small. The individual appraised the situation as refractory to change, and emotion-focused strategies predominated: omnipotent ideas of not needing anybody. Briefly, this afforded some coping efficacy, expressed in the idea of 'good riddance', but this was short-lived.

Problem-focused strategies were then employed in drinking alcohol to alleviate unmanageable feelings. This was also unsuccessful, in terms of both efficacy (the feelings became unbearable) and effectiveness (no positive influence was made on the external environment). A failure of coping mechanisms ensued and the overwhelmed individual took an overdose as an aberrant means of addressing unbearable feeling states.

It is possible to modify this process at a number of stages. Consider the same initial scenario but this time, following their CASP, the individual telephones a fellow member of the SUN Project before beginning to drink. This fellow member points out that this has happened before and the partner has always returned within a short period of time. Moreover, they recall, the individual has always survived and their friends have rallied round to help with practical matters. We can now see primary appraisal of the threat is less and secondary appraisal of resources is greater. Alternative coping strategies, other than omnipotence and alcohol use, can now be explored and successful strategies will positively influence subsequent appraisal. Moreover, this process can be carried out within SUN groups to prevent repeating patterns from perpetuating.

Therapeutic community adaptation

Based upon the concept of 'Community as Doctor' (Rapoport, 1960), the SUN Project model utilises the resources of the service user group to effect improvement in coping through the modification of appraisal and by practical means. As described above, all people who become members of the SUN Project complete a Crisis And Support Plan [CASP] in a group. This provides access to an individual's primary appraisal of the degree of threats that they face to their psychological integrity and their secondary appraisal of their resource to cope. By collaboratively completing this document in a group, the individual has access to the appraisals of others who begin the process of modifying the appraisals and influencing coping strategies for the individual. The process is not unidirectional and so established group members will also be influenced by the newcomer.

Technical considerations

During ongoing contact with the SUN Project, the ongoing elucidation and modification of appraisal and behaviour continues to be a therapeutic focus. Evidence shows that gaining access to a person's appraisals requires an active technique as non-directive approaches have been shown to yield less information (Bensing & Sluijs, 1985; Heaven & Maguire, 1997). SUN staff utilise active communication techniques to increase the yield of information on appraisals that have been shown to persist over time (Maguire, Fairbairn & Fletcher, 1986) and as such may be transferred from teaching settings to the workplace through supervision (Heaven, Clegg & Maguire, 2006). These techniques, translated into the SUN Project model, are supervised and taught

weekly and, during the allotted 2½-hour duration of groups, are utilised to identify and explore appraisals and response variables in order that they may be modified to improve coping outcomes.

Adapting coping process modification into a TC approach, including the wider context of service user involvement described above, also potentially enables boundary keeping and limit setting to become in part a function of the internal group process (Jones, 2005) so that it is possible to transfer enough ownership of group regulation to the SUN members to create a working partnership where agreed rules are more likely to be adhered to (Fuller & Miller, 2011). The structured approach to asking about appraisals and suggesting more adaptive ones is a route to fostering a 'culture of enquiry', the cornerstone of any TC (Main, 1983; Norton, 1992).

Psychoanalytic contributions:

In addition to cognitive and behavioural foci, a necessary dimension for work with people with PD is a focus on the relationship between therapist and patient (Davidson, 2000). Psychoanalysis places the therapeutic relationship at the centre of concern and, although techniques such as transference interpretations are not used directly in the SUN Project, a working knowledge of some key psychoanalytic concepts is considered essential. This is revisited weekly in the 'Psychodynamic discussion time' staff-training forum.

Consider for example the patient whose difficulties seem to worsen along with increased contact with health services. In his psychoanalytic account on violence, Glasser (1998) describes a self-preservative aspect to violence and core complex pathology as being at the heart of this presentation. Aggression displayed by the patient, which may be directed towards the self, stems from fear of either annihilation (from overwhelming closeness) or abandonment. Similarly, Bateman and Fonagy (2004) describe an 'approach-avoidance dilemma', where self-harm is seen as an attempt by the patient to preserve their thinking mind in the face of core complex anxieties. Taking account of these views, the open access SUN Project provides individuals with the autonomy to regulate their contact (approach) with others by choosing the frequency of attendance at the group, without fear of discharge (abandonment). As this process unfolds, the SUN member is helped to negotiate their core complex anxiety and develop the sense of a 'secure base' from which to explore (Bowlby, 1969). However, in contrast to the therapist's stance of open enquiry, the SUN Project often takes a more directive approach. We utilise psychoanalytic theory specifically as a means for understanding emotion-focused coping strategies and coping efficacy such that a better coping outcome may be generated. Emphasis is upon challenging the coping style of individual patients and providing practical less maladaptive alternatives. In our experience this provides a therapeutic option to a potentially more diversely disturbed and chaotic patient group.

We extend Kernberg's view of the centrality of splitting, primitive idealisation, early forms of projection, and especially projective identification, denial, and omnipotent defence constellations (Kernberg, 1968, p.600), as well as the

related concepts of transference and counter-transference, to our work with PD in general. The ‘undoing’ of such unconscious defensive mechanisms is achieved through the facilitation of challenges and ‘referencing’ by the group members towards one another, moving the individual in crisis away from an emotion-focused response towards a relinquishing of the associated defensive mechanisms. By ‘referencing’, we are describing the act of establishing oneself and others within a context-specific narrative (Jones & Miller, 2011), which in turn fosters the sense of being accurately perceived in history and now invited to think about present relationships (mentalise). The resultant ego strengthening that Kernberg points to affords the SUN member the opportunity to establish themselves in relation to their historical context within SUN, allowing the individual to ‘arrive at being’ (Jones & Miller, 2011) in the present and creatively engage with the world.

We should make clear here that the SUN facilitators undertake no formal psychotherapeutic or psychoanalytic training. Rather, the psychoanalytic concepts and associated dynamics are made clear within the supervisory structures that we have already described.

Clinical example A

The following clinical extract from a SUN Project group illustrates how some of these elements combine in the clinical model.¹

It is the week before Christmas. At check-in, group members discuss their anxieties about the holiday period. Some voice the temptation to take drugs or drink to excess, whilst others fear the prospect of spending time with family, or conversely not spending time with family. Most are worried about what the New Year will offer. The main part of the group (an emotional support group) then unfolds:

A: *I don't know why, I keep having thoughts about cutting again. That's what got me into the psychiatric ward last time, I cut all over my arms. Things are going OK outside now, I might get this volunteer job with people with learning difficulties. My kids are OK, I like Christmas usually, I don't know what it is.*

B: Are you sure it isn't Christmas, making you feel down, I know I think about how much I've lost ... my family and all that.

A: *I suppose I might be thinking about my mum, it was after she died that I started to have problems, but I don't think so. I haven't seen my dad for years anyway.*

C: Where do you think about cutting?

A: *Well, just my arms, I haven't done it for months, but the thoughts keep coming back.*

B: One thing I find helps is drawing on my arm where I would have cut with a red felt tip pen. I don't know why it helps but it does. I suppose it's kind of a visible sign.

¹ The content of this extract was agreed by members as representative of events in the group and permission to publish has been obtained from all those involved.

A: *I haven't tried that ... I don't know if it would work.*

B: Another thing is an elastic band round your wrist and you ping it hard when you want to cut. It can be quite painful. Those fat Oxfam ones are best.

A: *Yes, I could try that, where do you get them from?*

C: I've got a spare one. I'll give it to you in the break.

A: *Oh, thanks very much, I'd really appreciate that.*

Facilitator: Is that going to be enough to keep you safe, A, do you think? Maybe we need to get out your CASP and have a look at what you've got planned for when things start going wrong.

The facilitator produces a copy of the Crisis And Support Plan from the folder.

Pause ...

D: I was wondering if you had any worse thoughts than cutting.

A: *(looks very low) Sometimes I do, yes. It's just so strong at the moment. The thoughts keep coming and coming. I can't get away from them. I just want to be at peace.*

D: What are the thoughts about, A?

A: *Overdosing. I've only ever done it the once and I was really depressed, that was when I went into the ward.*

Facilitator: Are you actually having thoughts about committing suicide, A?

A: *I suppose so, I don't know why, I just can't get the thoughts out of my mind.*

Facilitator: OK well, we need to think about how to keep you safe ... your CASP says to give your medication to your wife to look after ... have you done that?

A: *I have yes, but I keep thinking about buying some more.*

Facilitator: You also wrote down to contact your Community Mental Health Team (CMHT), didn't you?

B: What about your CMHT, you've got a key worker haven't you? They helped you last time you were in crisis.

A: *Yes, but she's on leave at the moment. I have been to see my GP. I went last Tuesday to ask her to change my medication to help with the voices and she said she'd ask the psychiatrist. But yesterday when I phoned, she said he hadn't got back to her.*

C: But that's more than a week ago now. You shouldn't have to wait that long, not if you feel you're at risk.

A: *Well, that's why I went back to my CPN and she said she'd have a go, but when I rang yesterday they said she'd gone on leave until after Christmas. I've got an appointment to see her then.*

B: Well, I think we should support you to call your CMHT again because, even if your CPN is away, they should have someone on duty that can help. Let's call the psychiatrist.

Facilitator: How does that sound to you, A? Would you like to make the call now from the mobile in the group?

A: *I don't know really. Yes, I suppose I should.*

Within the group, A then telephones his CMHT and asks to speak to the consultant psychiatrist. He is told the psychiatrist is in a meeting and will return his call. The group returns to checking how other people are. The check-out part of the group is devoted to reflecting upon the group and ascertaining

whether there is anything else that needs to be done to help people leave as safely as is possible. The group is told A's CMHT has not called back. The facilitator is asked to call again because the group member feels he cannot manage it. She agrees and is told upon calling that the psychiatrist is now having lunch. Within a few minutes, however, the psychiatrist calls back and asks to speak to A. He stays in the group to take the call, telling the psychiatrist that he is having overwhelming thoughts about suicide and worried about 'the voices coming back' if his medication is changed. The psychiatrist reassures him this should not happen with the envisaged change.

B: Well, that was a result ... how are you feeling now, A?

A: *Oh, I feel much better, he said I can go over and get the prescription on my way home now and hopefully it should work. Thank you very much everybody, I really appreciate that.*

Following the Christmas break, member 'A' returned to SUN, reporting that he had changed his medication as suggested and subsequently felt better. He did not cut himself. He really enjoyed Christmas, commenting that the support of the group was really helpful in keeping him safe and allowing him to enjoy the festive period.

This extract highlights a number of the features typical of the work in SUN. The level of active enquiry by both the facilitator and group members is typical of our approach. With regard to coping process theory, member A's primary appraisal of what he faces seems vague. He is unsure of why he feels low. In his secondary appraisal, he does point to some available resources in his children and in the prospect of a voluntary job, but appears unsure as to whether these resources are adequate to prevent self-harm, his initial emotion-focused coping response.

The group members then become more active, with member A being offered additional coping suggestions by other group members (the red felt tip pen and the elastic band being alternatives to self-harming). These additional resources at the stage of secondary appraisal help A to move towards a more problem-focused response. At this point, the facilitator makes reference to the CASP, illustrating the central place that this document occupies in promoting a problem-focused response and reducing risk. With the aid of the CASP, the group members continue to explore the emotion-focused response, with the active enquiry about suicidal ideation helping member A to relinquish the denial of the violence involved in pursuing the wish to 'be at peace'. The group 'referencing' how member A has coped previously helps further promote a problem-focused response.

The initial outcome, wherein member A successfully makes contact with his CMHT and arranges his medication review, increases his sense of efficacy in managing the crisis. This may be 'referenced' in subsequent groups. When he returns, having actually enjoyed the festivities of Christmas, he conveys the sense of having been creatively engaged with the world; a far cry from the crisis he presented with.

Clinical example B

The open access nature of SUN carries the likelihood of mixed-gender groups with variegated histories (indeed this is the norm). One common anxiety voiced by members and community teams, therefore, is that vulnerable patients may come into close proximity with potential abusers. This second clinical example illustrates how emotion-focused coping strategies may be modified within the SUN Project by employing an understanding of psychoanalytic concepts.

After several months on SUN attendance, member C disclosed to the group his obsessive ruminations concerning a wish to harm children. Several other members, with histories of abuse, voiced a strong desire to expel member C from SUN. By contrast, when facilitators contacted the CMHT to address the risk, that team described this 'obsession' as a long-standing feature of member C's presentation (without any enactment) and one that should best be ignored. The team's stance may best be exemplified in their having placed member C in supported housing, next to a school. These two views – to deny or expel – sat juxtaposed. Alongside, member C resorted to serious self-harm outside SUN following each occasion he broached the subject of his ruminations in SUN, hitting himself with tools and sustaining facial fractures. On other occasions, he would attend group and support others in crisis, without any reference to his own disturbance.

Within psychodynamic discussion, the staff team were helped to understand member C's disclosure in terms of an unacceptable sexual fantasy which, under the dominance of a harsh super-ego, resulted in severe punishment or denial as temporary solutions to the intra-psychic conflict. These solutions were adopted by the group in their wish to punish (expel) and by the CMHT (in their desire to ignore). The task for the facilitators in the SUN group then became one of navigating between these two positions enough to attend to the risk in reality in a measured manner. That is, the facilitators had to act as an auxiliary ego capable of attending to the reality principle.

The SUN group members were then aided to first discuss their own experiences of feeling 'unacceptable' and worthy of punishment, like member C, which bore fruitful recognitions from other members. One member, though, left the SUN group, viewing this action as condoning member C's presentation. With the help of the remaining group, member C constructed a letter to social services using the group's words and sought a forensic psychiatric assessment, both undertaken in an effort to acknowledge the risk and seek a measured response. He was re-housed after a brief period of admission to a forensic unit. Since that time (over a year ago), member C has continued to attend the SUN groups, with no incidence of harm to children and no further acts of self-harm.

Discussion

We have described here a model for open access support groups delivered in community settings. At the time of writing, the original mode (first incarnation of SUN serving five London boroughs) has a membership of around 500 people, of whom on average 100 attend each month, and with a total of 2,500 contacts per year. The replicated SUN model, operating in another NHS trust to serve another London borough, has a membership there of 65 and an average group

attendance of 10. The SUN Project has been well received by patients, increasing a subjective sense of wellbeing, coping, and empowerment, and has reduced both emergency service utilisation and numbers of occupied bed days for psychiatric admission (Gillard et al., 2010; Miller & Crawford, 2010; Miller & Moore, 2011).

The initial success of the SUN Project, together with the replication, has been made possible by the development of a coherent transferable model. This model has proved easy to teach to health care professionals and service users alike and is economic to deliver. Staffing costs are relatively low as generic mental health professionals and service users are able to apply the model. Overheads are low as it is delivered in community settings such as church halls and community centres.

At conception it was not known how people with PD would utilise an open access service covering a highly-populated geographical area. One possibility was that the SUN Project would be overwhelmed. This has not proven to be the case. In fact, data on service use highlights the results of giving control over access to service users themselves. Attendance for individuals can be sporadic and is for many clustered around times of crisis. Over time we see people who have returned to the service a number of times after periods of extended absence. Whilst not in contact we remain a resource that they can access when they choose. Service users who chose to use the SUN Project in this way highly value being given this choice (Gillard et al., 2010).

For those that work with people with PD, safety is of paramount concern and for an open access service it is a particular issue. Clearly, safety is inseparable from the principal aim of the SUN Project to be supportive. The SUN Project model addresses safety in a number of ways. Beginning with the assumption that everyone that contacts us is potentially at high risk to themselves or others has enabled universal safe strategies to be adopted for all our possible client population without knowledge of an individual risk history (see Appendix 1). The requirement that a potential member of the project completes the CASP not only accesses primary and secondary appraisals but also provides information concerning behaviour in times of crisis.

This requirement offers a number of advantages. First, the active 'assessment' of an individual with PD by their peers is likely to yield accurate information as people with difficulties in common ask pertinent questions in a shared language, and barriers to disclosure such as shame are reduced. Second, by addressing these crises immediately, naming them in a group and writing alternative behaviours on a document kept by the individual, the first step towards a risk reduction has been taken. Third, risk (like coping) is not a stable phenomenon and alters according to circumstance; the repeated daily focus on current coping in all groups ensures that current risk, rather than past risk, is always the issue focused upon. Another factor that promotes safety is that we are clear and explicit concerning the situations where confidentiality does not apply (e.g. child protection issues) and where information will be shared outside of groups. For information received outside groups we operate a no-confidentiality policy; all communications to individuals, whether to staff or group members are brought into the groups for discussion. These combined procedures have the

effect of making all material available to modification of faulty appraisal and maladaptive coping. Secret-keeping is much reduced and risk to individual members or others can be openly discussed and dealt with in a straightforward way in the group. Staff must feel safe and comfortable enough to operate too. We have found that this structured method together with the relatively large percentage of time spent in supervisory and educational team activities are key factors in containing anxieties and maintaining fidelity to the service model.

Although useful, we are aware that the SUN model has limitations and potential for developments. As no individual work is undertaken, it can only help people who can tolerate groups (and disparate and conflicting histories within those groups). SUN groups cater for people with a relatively high level of disturbance and low social functioning, and would-be group members find this distressing and difficult to tolerate. It is possible that adding an individual component to the work and something less intense may increase engagement and possible effectiveness (Chiesa & Fonagy, 2003), although this would have resource implications and increase cost. It would also potentially conflict with the TC principle of 'community as doctor'. We make no claim that the SUN model caters for people with PD who need a residential treatment. However, we are investigating the possibility that the number that do so may be reduced by expanding the project to include community respite beds. Further developments include interest from a number of organisations in setting up local SUN Projects for themselves and we are working on further developing our teaching package and manualising our approach. Future research is needed to strengthen the data on outcomes for SUN members that relate changes in coping processes to empowerment and impact upon service utilisation.

Summary

This paper outlines the method of operation and theoretical foundations of the SUN Project, a service offering a partnership between members and staff, comprising open access groups for people with PD. Coping process theory, TC principles and psychoanalytic principles have been combined. This combination of principles provides us with a structured, coherent and replicable model that has been successfully applied to the work with people suffering from PD, both as a stand-alone service and as a service to complement another theoretical framework. The open access and open-ended policy of engagement helps redress the core-complex anxiety inherent in people with PD in their anticipation of contact with others, whilst the starting assumption that everyone presenting is a high risk, the use of the CASP and the highly-structured nature of the model all serve to promote a safe way of working. The ability of SUN members to reference one another within this structure affords the possibility of arriving at being creatively engaged with others within a therapeutic frame. The additional provision of core groups and an on call peer support system carries this creative possibility beyond the confines of any one group and into the outside world.

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