Original scientific article

Received on 28 February 2025, accepted on 20 May 2025

doi: 10.51741/sd.2025.64.1-2.45-70

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The process of deinstitutionalisation from within an institution: evaluating innovations in a closed ward for women with (borderline) personality disorder

Although UK Mental Health services have been de-institutionalised since the end of the 20th century, women with (borderline) personality disorder are often admitted compulsorily to closed psychiatric wards due to high level of self-harm. The paper focuses on the evaluation of introducing innovative intervention methods, alongside dialectical behaviour therapy, in the Daffodil ward which promoted the agency and self-responsibility of service users in managing their mental health. The evaluation reported in the article includes individualised photovoice followed by interviews of the inpatients, and in parallel receiving providers' reports about every three months. The photovoice method enabled service users to take photos representing their experiences on the ward; this provided a basis for interview content. The new interventions promoted the recovery and empowerment of service users and utilised the transformative role of peer support and experts by experience in improving ward culture. The interim findings highlight how the impact of an effective culture of experts by experience involvement and the introduction of a new service model can provide a context for deinstitutionalisation from within an institution, providing a template for future hospital service delivery.

Key words: *mental health, psychiatric ward, behaviour therapy, service users, recovery, photovoice.*

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Proces deinstitucionalizacije znotraj institucije: evalvacija inovacij na zaprtem oddelku za ženske z (mejno) osebnostno motnjo

Čeprav so službe za duševno zdravje v Združenem kraljestvu od konca 20. stoletja deinstitucionalizirane, so ženske z (mejno) osebnostno motnjo pogosto prisilno sprejete na zaprte psihiatrične oddelke zaradi visoke stopnje samopoškodovanja. Avtorice opisujejo evalvacijo uvajanja inovativnih intervencijskih metod, ki so poleg dialektične vedenjske terapije na oddelku Daffodil spodbudile samoodgovornost uporabnic storitev pri skrbi za svoje duševno zdravje. Evalvacija vključuje individualiziran fotoglas, intervjuje s hospitaliziranimi pacientkami in poročila izvajalcev približno vsake tri mesece. Metoda fotoglas je uporabnicam storitev omogočila snemanje fotografij, ki prikazujejo njihove izkušnje na oddelku; to je bila podlaga za vsebino intervjujev. Inovacije so spodbudile okrevanje in krepitev moči uporabnic storitev, k izboljševanju kulture na oddelku pa so občutno pripomogle vrstniška podpora in osebe, ki so strokovnjakinje za svoje osebne izkušnje stiske. Preliminarne ugotovitve kažejo, da lahko učinkovita kultura vključevanja takšnih strokovnjakinj in uvedba novega modela storitev zagotovita kontekst za deinstitucionalizacijo znotraj ustanove. To je potem vzorec za prihodnje izvajanje bolnišničnih storitev.

Ključne besede: *duševno zdravje, psihiatrični oddelek, vedenjska terapija, uporabniki storitev, okrevanje, fotoglas.*

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Introduction

A large-scale deinstitutionalisation of mental health services has taken place since the end of the 20th century in the UK leading to a considerable reduction in the number of people hospitalised from 52,000 in 2001, to 23,000 in 2022 (BMA, 2022). Women with (borderline) personality disorder may often self-harm and may be at risk of suicide or parasuicide and therefore are often hospitalised. Borderline personality disorder or emotionally unstable personality disorder is perceived as a disturbance in the regulation of emotions which is accompanied by poor self-esteem, with disbelief in the self-capacity to improve, as well as self-shame, difficulties in relationships with others, impulsivity, a high level of self-harm and experimentation with drugs which may lead to hospitalisation (NHS, 2022).

This group is vulnerable at the entry to an inpatient closed ward, likely to engage in serious self-harm and hence are hospitalised for safety reasons. Interventions to improve their condition may lead to 50% of success over time, but they often require long term support (Zanarini *et al.*, 2010). This article outlines an attempt to introduce new methods of working with this population and the evaluation of this initiative from the perspectives of both the women and the service providers who work with them.

Deinstitutionalisation is reviewed in this article, followed by consideration of the needs of women diagnosed with (borderline) personality disorder. The newest innovations are considered as to their impact on reducing/eliminating self-harm and their transition to the community from a closed ward. The article provides a context for the implementation of expert-by-experience programme at the private mental health provider, and key innovations in the ward which have been taking place since the beginning of 2024.

An interim evaluation of these innovations is presented. The findings highlight how the impact of a culture focused on engaging with the inpatients, and listening to experts by experience, as well as a range of activities on the ward can provide a context for deinstitutionalisation within an institution. It provides new insights into understanding the ongoing relevance of deinstitutionalisation theories and how effective innovations can provide a template for future service development within closed wards for women with (borderline) personality disorder.

Background

UK deinstitutionalisation policy and process have been led by the belief that a community mental health services system provides the best support for people with mental health needs of all ages and levels of need, supported by the legislation of the UK Community Care Act (1990). These processes established more community services, such as crisis intervention home treatment teams, and in a few places, new day centres focused on recovery and integration to the community (Castillo, 2016). The introduction of the Direct

Payment scheme in the 1997 enabled people to have more choice in the type of services they wanted and could have (UK CIL, 2024).

While the UK government was primarily interested in saving money, UK mental health professionals, informal family carers and active service users, alongside the voluntary sector, focused on establishing the most effective care provision within the community. Most current hospital inpatient beds are now located in psychiatric wards within general hospitals.

By February 2024 there were estimated to be 17,836 such beds, the lowest ever number (Statista, 2024). Yet the number of hospitalised days has gone from 32 in 2001 to 39 in 2023, indicating that the issues leading to hospitalisation continue to require our attention (BMA, 2022). While the three special forensic psychiatric hospitals continue to exist, many ordinary psychiatric hospitals have been closed. The process of reduction of beds is ongoing although not surprisingly, the Covid 19 pandemic, of 2020 to 2022, alongside the poor economic climate since 2008, led to increased demand for mental health interventions (BMA, 2022), especially among young people. The UK system offers a national health service to all citizens, and indeed most mental health facilities are run by NHS units, although Daffodil ward is located within a private mental health provider organisation.

During deinstitutionalisation processes, a reduction in stigma has been observed and public fear of violence from people experiencing mental ill health has reduced; though not in full. Periodically instances of violence by this population group occur, although most of the time they are themselves the victims of violence (Rettew, 2023). Recent updates show that 88% of people experiencing mental ill health have not engaged in any violent behaviour, and only 4% of violence perpetrated could be attributed to mental illness. We do not have sufficient research concerning violent behaviour by either staff towards service users in closed wards, or conversely.

There are many calls for improving mental health services both in hospital settings and in the community (Johnson *et al.*, 2022). Montenegro *et al.* (2023) in a scoping literature review underline that successful deinstitutionalisation requires the need to: undertake a sufficient needs assessment of the institution population, provide appropriate financial investment for transition, develop the workforce accordingly, and to carefully monitor implementation and quality.

More women experience (borderline) personality disorder than men (at a ratio of 3:1), most of whom have a normal to a high IQ. While it appears in only 3% of the general population, its percentage in clinical settings is much higher (with rates of 6.4% in primary care visits, 9.3% in psychiatric outpatient, and 20% in psychiatric inpatient). The rate in the general population is equal between men and women, raising the possibility that the much higher rate in clinical settings is due to more women experiencing borderline personality disorder seeking help more than men (NHS, 2022).

A range of often intense negative emotions are experienced, such as rage, sorrow, shame, panic, terror, long-term feelings of emptiness and loneliness.

Borderline personality disorder is treatable, especially with the application of individual and group dialectical behaviour therapy (Gillespie *et al.*; 2022, Hernandez-Bustamante *et al.*; 2024, Vijayapriya and Tamarana, 2023); however, this intervention requires a high level of service input. Personality disorder covers 10 possible diagnostic categories, of which borderline personality disorder is the most frequent, followed by anti-social personality disorder.

Therapeutic work with borderline personality disorder in the UK

Service users with (borderline) personality disorder may require long term inpatient stays to support their recovery, although often successful short-term interventions are sought, especially during inpatient admission for personal as well as for economic reasons. Helleman *et al.* (2014) have reported how Brief Admission Interventions can be very helpful in managing acute crisis and providing a safe space for interim self-harm reduction. However, for some women, short term hospitalisation may be less successful. In a first-hand account, Williams (1998) argued that repeated hospitalisation denies people with borderline personality disorder the autonomy and agency to take control of their own recovery; thus requiring longer-term treatment.

Stapleton and Wright (2019) underlined the helpfulness of hospital inpatient stays for some service users with borderline personality disorder. A meta-analysis of eight primary qualitative studies and three first-hand accounts of the experiences of inpatient stays for this population revealed the following positive factors from the inpatient experience: opportunities to be listened to and to talk to staff and peers, timeout from daily life and feelings of safety and control were perceived as positive elements of inpatient care. Negative experiences were attributed to a lack of contact with staff, negative staff attitudes, staff's lack of knowledge about borderline personality disorder, coercive involuntary admission and poor discharge planning. This comment thus emphasises that it is important for people with borderline personality disorder to be empowered to share responsibility for their own recovery, as indicated in the Springbank model which promotes a long-term hospital stay building on successful future focused recovery (Nagrodzki and Zimbron, 2019; Henry *et al.*, 2021; Yue *et al.*, 2023).

Recent innovations have been developed to support women with (borderline) personality disorder. The Haven project (Castillo *et al.*, 2013; Castillo, 2016), located in Colchester (UK), and Springbank ward in Cambridge (UK), have demonstrated that enhancing co-production, shared decision-making and applying dialectical behaviour therapy can make a considerable positive difference to the lives of females with borderline personality disorder.

The Haven (Castillo, 2016) was a day centre with a crisis residential unit for females with borderline personality disorder. Out of 139 referrals 69 made suicide attempts and 59 self-harmed in other ways (Castillo, 2016).

It offered dialectical behaviour therapy, and a variety of day activities. The residential unit enabled women to stay there when in crisis for up to three weeks, treated by professional staff members, thus preventing the need to use long-term hospitalisation, and reducing substance misuse. A special project offered training to several service users to become trainers in other services for people with personality disorder. The centre was successfully managed jointly by the staff and peer representatives. Outcomes indicated an elevated level of success in preventing many hospitalisation days, use of police, and reduction of use of eating disorder services. A carers support group was established. A group of service users and Dr. Castillo ran the research aspect of the centre over two years, leading to several publications in peer reviewed journals and two books.

Springbank closed ward for female borderline personality disorder successfully embarked in 2016 on a new intervention regime which included individual and group dialectical behaviour therapy, shared decision-making between service users and providers focused on medication and the transition to the community planning and revoking compulsory admission for voluntary admission upon entering the ward. The outcomes demonstrated the reduction of critical incidents and major tranquilization to zero by 2019, which has continued to be maintained (personal communication from the consultant psychiatrist of the ward, 2024), alongside an increase in taking self-responsibility as well as increased satisfaction for both service users and staff from the ward regime. One woman moved from being a service user to becoming a peer support worker in the ward.

A small scale qualitative project in Springbank (Nagrodzki and Zimbron, 2019; Henry *et al.*, 2021), focused on exploring both staff and service users' perspectives of the ward environment, indicated that the usually one year long therapeutic programme offered at Springbank to new service users, co-produced with them, supports women with borderline personality disorder to recover after failing to benefit from acute ward admission and community psychiatric treatment prior to entering Springbank. Moreover, sharing the responsibility for recovery with the person, increases their engagement with the service, even if this co-produced vision for recovery may in the short-term increase their anxiety. This shared ownership of the process of recovery incorporates elements of positive risk-taking in people's choices about chronic self-harm and suicidality and increases the feeling of safety. The positive relationship developed between staff and service user is both therapeutic and personalised, has increased the sense of shared decision-making and co-production on the ward.

The adoption of a very similar, but not identical, innovation programme in Daffodil ward in a private mental health hospital in the Southeast of England, came about through the introduction of the Springbank model to a group at the Royal College of Psychiatrists in 2022. Key members of the Daffodil ward staff visited Springbank and decided to adopt the two key innovations practiced there.

Expertise by experience at provider organisation

At the provider organisation, the expert by experience programme plays a vital role in bridging the gap between service users and staff within inpatient settings. Unlike some organisations, experts by experience are identified as individuals who have directly experienced the types of services they now support and represent, rather than those with carer perspectives. This distinction ensures that feedback and insights come directly from individuals who understand the complexities, challenges, and nuances of being an inpatient, which is consistent with research showing that peer-led initiatives improve user engagement and service outcomes (Repper and Carter, 2011). Family carers, while highly valued, are identified separately as Carer Ambassadors, recognising the unique contributions they bring to care delivery and development.

All experts by experience are employed in paid roles, reflecting the organisation's commitment to valuing their unique contributions and lived expertise. The paid role also provides financial security, incentive and purpose for the experts by experience whilst also fostering a culture of equality with other paid professionals. This approach aligns with best practices in the equitable inclusion of those with lived experience in service development (Basset *et al.*, 2010). During their weekly visits, experts by experience focus on building relationships with service users, offering peer support, and creating opportunities for meaningful dialogue. Such peer-based approaches are well-documented for fostering trust, promoting recovery, and enhancing the therapeutic relationship between service users and the system (Gillard *et al.*, 2013).

Experts by experience play a crucial role in the ongoing development and improvement of service delivery. By capturing feedback from service users during regular visits, experts by experience help to identify issues, patterns, and areas for growth within the service. Staff and management are encouraged to incorporate this feedback into action plans and service adjustments. Such feedback loops exemplify the principles of coproduction, wherein individuals with lived experience act as equal stakeholders in shaping services (Slay and Stephens, 2013).

In addition to gathering feedback, experts by experience play an important safeguarding role. Their presence serves as a preventative measure against the risk of closed cultures, where insularity within the service may lead to inadequate care practices or neglect of service user needs. The importance of this role is underscored by recent recommendations to integrate lived experience perspectives as part of safeguarding efforts in mental health settings (NHS England, 2021). By observing the interactions between staff and service users, experts by experience can identify emerging concerns and raise them proactively. This safeguarding role complements their efforts to create positive cultural change based on co-production principles, fostering a sense of empowerment and inclusion for service users.

While experts by experience focus on the inpatient experience, family carer ambassadors engage in training, meetings, and projects to enhance collaboration between families and services through the carers network. Through their work, carer ambassadors complement the efforts of experts by experience, reinforcing the provider's commitment to involving all stakeholders in the development and delivery of high-quality care, ensuring that they are central to the organisation's mission of continuous improvement and compassionate care.

Evaluation of the closed ward for women with (borderline) personality disorder

Innovations on Daffodil ward, building on the expert by experience programme at the provider organisation and the Springbank model provide a unique opportunity to deliver deinstitutionalisation from within. The next section provides an interim evaluation of a one-year evaluation of innovation on Daffodil ward. The study data collection runs from Jan 2024 to June 2025. Initial results from the first two data collection points are presented.

Methodology

We applied mixed methods to the study, utilizing photovoice to capture the participants' perspective in a creative way, followed by online interviews. The interview, which included their explanation of the photo's choice they made, enabled us to capture qualitative data about inpatient experience. This was supplemented by staff reporting every three months over one year. All eligible service users were offered the opportunity to participate in two half days of interactive training on the use of photovoice and their participation in the study. Topics included the use of appropriate photos, ethically taken, to submit for the photovoice interviews, considering the types of photos that could not be taken, and the need to either ensure the anonymity of any person in a photo, or to obtain their written consent in any pictures they could be identified. All ward staff were offered several opportunities to learn about the project, including direct briefing of those staff filling in regular reports. Staff reporting included the number of critical incidents and major tranquilization instances, move from compulsory to voluntary admission status, assessments of the learning and interaction of participants in dialectical behaviour therapy individual and group sessions, shared decision-making concerning medication use, skills training, unsupervised visits outside of the ward, and planning the transition to the community.

Service users were asked to choose a pseudonym which was applied systematically to any data collected about them, and only the researchers had the list of their real names. This list was kept in a password protected file.

Baseline interviews focused on understanding the service users' current situation from their perspective, whilst subsequent data collection periods centered on identifying the changes participants experienced between the phases, inclusive of the planning process of moving out of the ward back into the community. All interviews were undertaken online. The interviews were audio recorded and then transcribed, using the automatic Microsoft word document facility. The duration of each interview was up to 60 minutes. The transcript was available only to the researchers and was also password protected. Transcripts were cleaned manually by both researchers. Data from all modes of collection was analysed following each period using Reflexive Thematic Analysis (Braun and Clarke, 2022). It allows analysis of significant amount of data from multiple participants to be analysed and synthesised into meaningful accounts. A five-step of compiling, disassembling, reassembling, interpreting and concluding is to be applied. In the context of reflexive thematic analysis, the raw data forms codes, codes form themes and thematic maps, whilst the identifications of the themes result in interpretation with conclusions responding to the research question. The same type of analysis was applied to the periodical reports by staff members.

At the end of the study, participants will have the opportunity to have three of their photos displayed at an online exhibition, using the pseudonym they have chosen. An all-staff online questionnaire will be circulated at project-end to capture providers' views of the ward innovations.

Sampling

All 16 service users, residents on the ward, were eligible for recruitment to the study and asked to participate. Service users join the ward at different times during the year, and thus are ready to transition to the community at different times, therefore, service users joined the study at diverse times in their treatment regime. To mitigate this limitation, the study had two simultaneous cohorts involved in the study. Moreover, because this is a very vulnerable group, and the residents were asked to consent to participate in the study, not all service users consented to participate. In the first cohort, 6 participants consented, one left the ward early; 2 participants chose to join the second cohort. One resident in the first cohort chose to undertake the first interview, but then chose not to be interviewed the second time, but she consented to her reports being included in the study. The one who left early allowed her data to be retained in the study.

Ethical approval

Favorable ethical approval was obtained through UK National Health Service Integrated Research Application System (project id 327734). Both service users and reporting service providers were provided with an information

sheet and asked to give signed consent to participate in the study. The consent process was facilitated by an independent staff member, not attached to the ward but available on site, to prevent any conflict of interest. Service users experiencing a diagnosis of Borderline Personality Disorder can experience high levels of emotional distress; thus, interviewers had to be sensitive to the participants' needs and flexible in rearranging interviews on numerous occasions. The needs of participants took precedent during all contact points.

Key findings

Critical incidents

Self-harm is commonly practised by women with a diagnosis of borderline personality disorder to manage distress (NHS, 2022). The Mental Health Act (from 1987, amended in 2007) enables service users, experiencing severe distress, to be compulsorily detained in hospital under certain strictly defined criteria if they are at risk to themselves. Some service users may enter this ward compulsorily or can be returned to the ward by police if they are at risk of harm. A predominant reason for service users' admission to the ward is the incidence and severity of self-harm. Table 1 provides a summary of critical incidences, including occurrences of fixed ligature, cutting, violence towards staff, head banging, absence without leave, suicidal potential such as being next to train tracks, burning with aerosol.

Table 1: Summary of critical incidences.

Period 1: 31.01.24–01.05.24

Pseudonym	Period 1: number of incidences	Types of incidences	Number of particular incidents	Follow up care provided
Angel	20	Suicidal behaviour Ligature Cutting	1 18 1	Taken to Hospital Accident and Emergency Dept (A&E) None None
Bluedog	9	Suicidal behaviour Ligature Headbanging Burning with aerosol Cutting	2 2 3 1 1	Taken to A&E (1) Restraint to remove ligature (1) None Taken to A&E First aid given
Greenfrog	2	Headbanging	2	None
Roadmanjobs	3	Punched a wall Cutting	2 1	None Needed surgery
Simon Garfunkel	5	Punched a wall	5	None
Superstar	9	Headbanging Ligature Punched walls	4 1 4	None

Pseudonym	Period 1: number of incidences	Types of incidences	Number of particular incidents	Follow up care provided
Second cohort				
Poppy (19.06.24 – recently arrived on ward)	0	0	0	0
Purplestacey 23.01.24–26.06.24	36	Selected examples Headbanging Ligature Burning with aerosol Shouting at staff attempted AWOL (Absence without leave) from hospital Cutting Incident of alcohol use and being overly intoxicated	 16 8 1 1 5 3 1	 Resulting in restraint (9) None None None Restraint (5) A&E attendance (1) First aid (1) None (1) 1

Period 2: 15.05.24–15.08.24

Pseudonym	Period 1: number of incidences	Types of incidences	Number of particular incidents	Follow up care provided
Angel	9	Suicidal behaviour Ligature Cutting Punched wall Security incident	1 5 1 1 1	Taken to A&E None None None None
Bluedog	6	Headbanging Cutting	4 1	None None
Greenfrog	2	Headbanging	2	None
Roadmanjobs	3	Overdose	3	A&E attendance (3)
Simon Garfunkel	4	Punched a wall Had an altercation with member of public	3 1	None Called ward for support
Second cohort				
Poppy	10	Non fixed ligature Headbanging Cutting	7 2 1	0 0 Wound dressed
Purplestacey	15	Ligature Overdose Cutting Punched wall Security incident	5 1 1 1 1	None Taken to A&E None None None

Service users experience high levels of distress, both prior to coming on the ward and after their ward admission. There is a significant reduction in the number and severity of critical incidents between the two data collection periods. Moreover, the strategies put in place by the ward focus on identifying recovery goals to ensure effective transition to the community, emphasising

the development of self-esteem and self-worth, promoting a ward environment based on recovery through the regular provision of activities, and building of relationships with staff and peers. This approach is extensively supported by both group and individual dialectical behaviour therapy. These themes capture the complex web of interdisciplinary support put in place to successfully support these women, both during their ward stay and after their transition to the community.

Planning for successful transition to the community

On this ward, women are most often discharged from compulsory detention around three months after admission. This is a step which indicates being less ready to take the risk evident in the Springbank model in which compulsory detention is revoked immediately on admission. Identifying clear recovery goals with a clear pathway to leaving the ward is key to successful transition back to the community at the end of the ward stay, and a focus on the therapeutic alliance to support transition decisions is essential to all types of support offered on the ward.

Most of the service users are ambitious women. However, there is less of a significant self-identity with some participants experiencing gender identity fluidity and self-doubt in their abilities and capabilities. Their ambitions are identified from an early stage with staff support concerning future life directions. For example, although Angel was less willing to engage with ward activities, she expressed a desire to become a childcare worker. Bluedog, although experiencing acute distress, continued her studies in Healthcare level 3 via distance learning, with an ambition to become a mental health nurse. On leaving the ward, Greenfrog will take up a place at university. The focus on long term goals and transition is developed by engagement on the ward. Roadmanjobs notes:

> We talk a lot about like values and sticking to those values to make a life worth living. And since I'm in a much better place now, I'm more able to understand. (Data collection period 1)

This is supported by effective transitions planning, as detailed by Superstar.

> Discharge book… Yeah, if there is a plan then they discharge you near my mum's. I got photos in my discharge book I've got my hobbies. What I like, what I don't like, what I wanna live in a bungalow. And just pictures really. (Data collection period 1)

For some interviewees transition to the community was very difficult. Purplestacey experienced 15 critical incidents in data collection period 2, although this was significantly less than the 36 incidents experience in period 1. She experienced much distress and attempted self-harm. She found it hard to motivate herself and tended to spend a lot of time away from the ward, engaging less in activities

> I don't know what to really do as an activity, but I'm mostly out all of the time. (Purplestacey, interview, data collection 2)

She found it hard to envision a future outside of mental health services but would like to go to college to study childcare. However, when asked about how to achieve this, she couldn't identify the steps towards the goal, stating:

> Not really at the moment, cause trying just focusing on myself until I actually know what I want with my life when I'm out of here. (Purplestacey, interview, data collection 2)

However, the complexity of people's experience and the need for continued engagement is key to supporting the recovery of this service user group, as identified in the Purplestacey's occupational therapy report:

> Purple Stacey fluctuates between wanting treatment to not wanting to engage meaningfully. Hence needing redirection to visit goals and ensuring that they have a tangible experience on X ward. (OT report, data collection 2)

Self-esteem and self-worth

The feeling of self-worth and the role of self-esteem and ambition are key parts of recovery and transition to the community. Shared decision making is about sharing power between people involved in a mental health consultation process and enabling the best outcomes to be achieved for the service user, in partnership with the staff (Ramon *et al.*, 2017). The process of shared decision making enables a person with (borderline) personality disorder to take greater responsibility in their own care, namely around the desire to self-harm, which can be undertaken to manage past trauma and express distress (Nagrodzki and Zimbron, 2019; Henry *et al.*, 2021; Yue *et al.*, 2023). The intention is to create a sense of self-responsibility enabling the service user to be in control over their own lives, for which they need to learn to manage their own distress and risk (Henry *et al.*, 2021). This is at the heart of shared decision making, which is a process of sharing information, control, and risk in a person's life (Ramon *et al.*, 2017; Elwyn *et al.*, 2017). Shared decision making studies (Stovell *et al.*, 2016; Slade, 2017; Ramon *et al.*, 2017) have highlighted that to achieve successful shared decision making it is necessary to have mutual respect and trust as core conditions, and to consider power differential between the partners to this process.

On the ward, there is an emphasis on shared responsibility and shared risk-taking enabled by skills taught through dialectical behaviour therapy and other peer-related activities. In the research, women reported that peer leave, a practice at the centre of ward care, was a way to leave the ward in a safe and supportive environment where peers shared responsibility for self-care. The emphasis placed on valuing expertise by experience is key to building self-esteem. Being a ward peer support facilitator has given Greenfrog a sense of responsibility on the ward

> It's helped me feel like it's helped me feel like more, I don't know, like, independent and, like, responsible for something. (Greenfrog, data collection period 1)

Greenfrog reported how in preparation for discharge, she managed her own medication, remembering the times and dosage – thus taking responsibility for her own care. She reported her sense of empowerment through this experience.

> I mean on this day I was able because I have them in my room, I was just able to like, take my meds out with me and that was nice, like not having to ask for permission. I can just like give my own meds. That was like a nice independent thing. (Greenfrog, interview, data collection 2)

Shared decision making also demonstrates to the service users that staff members trust them sufficiently to give them more responsibility.

Hospital environment, activities and meaningful occupation

Service users living on the ward often stay for over one year. They may have come from other acute wards or placements where they have not succeeded in making a good recovery. The hospital offers a set of services provisioned by a multi-disciplinary team of practitioners to ensure successful transition to the community. Provision includes specialist dialectical behaviour therapy and psychological support, occupational therapy support, social worker support, and specialist psychiatric medication support. Additional activities to support successful transition are also offered. The reports provided by diverse professionals indicate the integration of inter-disciplinary care which provides a focus on recovery for all service users. Selected activities include:

- Vocational skills practised in the hospital shop
- Plan my week
- Volunteering/vocational roles
- Occupational therapy clinic
- OTA clinic
- Walk and talk
- Therapies clinic

And hospital activities include:

- Coping skills
- Art and wellbeing
- Know your own risk
- Mindfulness and relaxation
- Social communication
- Music and me

Such activities enable focusing on tangible recovery goals and support the women to follow interests and motivation for their own recovery. Greenfrog chooses which activities she does on the ward:

> Yeah. They I think they have like a list of the groups that they're going to run and you can sign up for different groups. Yeah, and then you can come when you want. (Greenfrog, data collection period 1)

However, becoming more independent, she has begun to participate less in them.

> Yeah, that's there's lots of like, hospital wide groups that, yeah, that you can choose from. I don't. Yeah, I don't go to that many anymore, because, I'm like going out more and going home more, but there's quite a lot going on, yeah. (Greenfrog, data collection period 1)

One service user highlights the usefulness of OT reflective time:

> And because like say, in the past week, since I don't come every week, the reflection just helps me put things into perspective. (Roadmanjobs, data collection 1)

The cooking academy was particularly commended by two service users. Greenfrog commented how the cooking academy supported her to become more independent and to move into the community.

> Yeah, that was main meal and that was like we went out to, was like a local… it was like a community hub where they had this big kitchen. We go on leave so I could do it and with the chefs, with the chef that works in the kitchen downstairs. More, but there's quite a lot going on, yeah. (Greenfrog, data collection period 1)

The positive relationship developed between staff and service users is both therapeutic and personal and increases the sense of shared decision making and co-production on the ward. Inter-disciplinary support by all professionals on the ward highlights the united multi-disciplinary response needed to support service users. Greenfrog experienced lack of motivation and engagement with many aspects of the ward environment. The occupational therapy report at period 1 reported:

> At the start of admission her engagement fluctuated massively and she was unable to depict long term goals. (OT report, data collection 1).

Furthermore, Greenfrog experiences mobility issues on the ward. At the first data collection point, a picture of her wheelchair was chosen as her photo.

Photo 1: Greenfrog's photo of a wheelchair.

(Greenfrog, data collection period 1)

Paradoxically, the wheelchair represents freedom with restrictions. It gives her the freedom to go out with friends, but also restricts and limits her access. She experiences pain when walking and using crutches.

> Like my wheelchair, as much as I don't like the fact that I need it, but it's giving me a lot of freedom. Like to go out and like not be in pain, and like it's not the best for mobility but like it's meant that I can do things like go to X Park and stuff where if I was just like walking on my crutches or like before when I was walking it was worse, but I wouldn't have been able to do those things. And like kind of accepting that this is what I need at the moment. (Greenfrog, interview, data collection 1)

She reported that engaging in the walk and talk group enabled her to practise her mobility and talk in an informal and supportive environment to other service users. At the second data collection period, Greenfrog showed a picture of a less accessible beach that she went to visit with a friend from the ward (Simon Garfunkel). The wheelchair exists in the background.

Photo 2: Greenfrog's photo of a beach.

(Greenfrog, data collection period 2)

She suggested that the photo represented:

> It's like it's similar like freedom and choice and doing things that I want to do. And I mean I feel like the wheelchairs like further in the distance and maybe that's like the next stage of my life being further away from that stuff. I mean being able to maybe manage without it or with using it less. Maybe. Hopefully in the next three months it won't be in the photo at all… In the last time [photo 1] it was like right near the front and like very much of that and in the space, I feel like it's still there, but it's like… It's a smaller thing. (Greenfrog, interview, data collection 2)

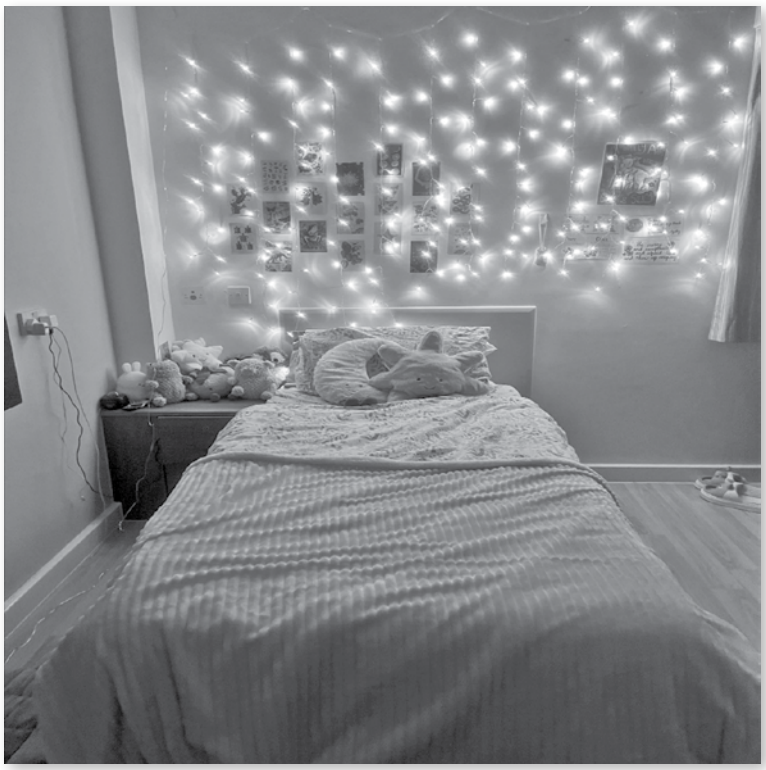
This simple but effective group activity was both empowering and supportive. Following the second data collection point, she started a course at a university, being supported by the social worker in applying for all necessary benefits. The experiences of peer and group leave are seen as effective for supporting independent engagement in the community.

The ward environment is sometimes busy, but with the noise of alarms and other service users engaging in self-harm, it negatively impacts emotional wellbeing.

> Sometimes the noise... And sometimes the self-harming and it upsets me sometimes. And sometimes when someone self-harms and I'll see, I keep my distance and I won't talk to that patient. But then I'll come round and speak to them again. (Superstar, data collection 1)

Bedrooms are personalised and often seen as a safe space, "a haven". Greenfrog data collection period 1 provides a picture of the room on the ward.

Photo 3: Greenfrog's photo of her bedroom.



(Greenfrog; data collection period 1)

The photo 3 show a personalised room.

> This is my room on the ward now. I think it's just like when I came here, my room was completely empty. Like I just had the light blue mattress and the old blanket and now I've got like all of my own stuff that were more covered in fairy lights and it just makes me feel like I've come a long way. (Greenfrog, data collection period 1)

Raf Hamaizia, the third author of this article and one of the study's lived experience advisers, recognised the significance of this photo to people who are resident on a hospital ward; the string of fairy lights poses a potential ligature risk. Thus, to have this item in Greenfrog's room represents the level of trust from staff and the extent of Greenfrog's recovery. Moreover, this photo captures the true potential of photovoice in revealing inner most experiences, even if the significance of the image isn't immediately recognised by either the participant themselves or the researcher. Furthermore, such key insight underlines the ability of lived experience contributors to meaningfully influence research processes and analysis (Ramon, 2003).

Some women experience a lot of distress. Angel was interviewed at period 1, then chose not to be interviewed at period 2, but allowed us to receive

her staff reports. Vocational activities are also initiated to support her recovery which she is sometimes reluctant to engage with.

> They often decline groups offered if they have engaged in maladaptive behaviours the night previous to offer. Angel also prioritises plans with peers on the ward and friends from her home town. Angel often spends time at the local town centre and or books hotels with peers. (OT report, Angel, data collection period 2),

However, the interdisciplinary engagement seeks to promote an environment of positive risk taking in preparation for transition to the community:

> They are also working towards building a routine that is meaningful and supports a positive identity. Angel is working on developing vocational skills and commitment by engaging in a paid role in the hospital of looking after the guineapigs (OT report, Angel, data collection period 2)

Managing urges to self-harm and to participate effectively in routines are important parts of return to everyday living which are key objectives of her dialectical behaviour therapy plan.

Relationships and systems

Relationship based supports plays an important role in the process of care. This is emphasised both in the role of peer support and staff support. Peer support is promoted through activities such a peer leave and group work in recovery such as the walk and talk group. These activities were acknowledged by many as being an important part of their recovery. The process of shared decision makeing and positive staff relationships, based on respect, care and non-judgemental approach to self-harm, modelled positive relationships which increased self-responsibility in managing distress. This was further supported through the implementation of group-based and individual-based dialectical behaviour therapy which taught skills to manage the urge to self-harm.

Moreover, many service users reported how they experienced staff as supportive and non-blaming when they engaged in self-harming behaviour, feeling able to look up to staff (Bluedog). Yeomans *et al.* (2015) highlight the importance of an integrated approach to supporting people with personality disorder, focusing on building therapeutic alliance with staff and maintaining the safety and wellbeing of the person with personality disorder. This may contrast with some health care experiences, which are less helpful, in which service user report being blamed and stigmatised for self-harming and can receive very negative care (Stapleton and Wright, 2019). Ward staff were experienced as very valued and seen as empowering and supportive:

> No. It's different to any other hospital I've been to how the staff treat you, and I think it's better. (Purplestacy, data collection period 1)

This positive relationship is reported despite Purplestacey's sometime apparent indifference, as reflected in the dialectical behaviour therapy report provided by staff:

> Purplestacey can appear to act as if they are indifferent, when in discussions with the team. This has often been because they are expecting a negative experience and to be told they are not engaging effectively. (Purplestacy, data collection period 1, dialectical behaviour therapy report)

Consequently, from their experiences of receiving positive care, some service users reported the wish to become mental health nurses, based on the model of support they had received (Poppy).

The social worker plays an important role in ensuring connections between family and community and supporting transition-planning to follow up community placements. Moreover, additional activities on the ward, aimed at developing independent living skills, such as cooking, were often mentioned to be very helpful in building capacity to move out of the hospital.

> Purplestacey has been able to build positive relationships on the ward with both peers and staff, whilst they have improved in taking notice when aspects of relationships are not working so they will address these experiences. (Purplestacy, data collection period 1, dialectical behaviour therapy report)

Despite this, it has been clearly reported in many of the traditional total institutions, latterly in the UK in the 1950s and 1960s, and more recently in former Eastern European countries, that the process of institutionalisation separates service users from their families. A total institution contains people within an environment that isolates them from their communities especially in a closed ward.

Due to the nature of (borderline) personality disorder, which is often related to (childhood) trauma, many women experience difficult relationships with families or are care-experienced. People with borderline personality disorder usually develop this in adolescence or early adulthood. Consequently, it is difficult for them to develop mature and lasting relationships, or to function successfully at home, educational settings and the workplace. Failures in these areas accentuate feelings of rejection, depressive moods and self-destructive impulses. Simon Garfunkel lost her mother prior to coming onto the ward. In data collection period 2 she states:

> I've never been a very spiritual person. I'm still not really, but obviously since losing mum, I look at death differently. With the grief, and I think that's to be expected. And sometimes whenever I'm missing her, I'll ask her to kind of send me a sign. (Simon Garfunkel, data collection period 2)

This experience is reflected in the occupational therapy report:

> Simon Garfunkel would like to gain more knowledge regarding who they are as an individual, and gain insight into coping with living with their past. (OT report, Simon Garfunkel, data collection period 2)

However, as they begin to build on their self-esteem and self-value they start to note:

> Simon Garfunkel has started to notice that people might like them and their characteristics. They have noticed qualities in themselves that they have previously disregarded. Whilst beliefs of being a worthwhile person are forming, they also require strengthening, which Simon Garfunkel explained they want to do. They have noticed starting to believe they want to live for themselves as well as their family, as previously their purpose for living was purely for others. (Dialectical behaviour therapy report, Simon Garfunkel, data collection period 2)

This sense of building relationships is shown in the picture provided by Simon Garfunkel at data collection period 1, depicting geese in a local park.

Photo 4: Geese by Simon Garfunkel.

(Simon Garfunkel, photo data collection period 1, depicting geese in a local park)

> You know, I've built up trust with them. They're coming to eat out of my hands now, both of them. (Simon Garfunkel, data collection period 1)

Building relationships with such animals is important:

> I've spent a lot of money on bird food and it's been worth it because the impact that they've had on me is huge as well, and it's somewhere that I've gone even on the days where I'm feeling the worst and when it's been hardest to

> stick to recovery, I've gone there and I've practised mindfulness and... And it's been someone where it's safe to do that. (Simon Garfunkel, data collection period 1)

And indeed, this is reflected in the experience of them making friends with pensioners outside the ward at the local park.

> I've made connections with people and real, genuine, connections in my adult life that hasn't been in the context of mental health and of hospital. (Simon Garfunkel, data collection period 1)

Building peer support can be very helpful, and developmental. Improving inter-personal relationships is seen as key to the recovery of people on the ward.

> Roadmanjobs initially was quite isolated on the ward. They have now been more effective at maintaining and establishing good relationships, whilst also being able to communicate her needs more effectively. Roadmanjobs' communication of needs is often prompted by staff. Her communication could be further enhanced. (Roadmanjobs, dialectical behaviour therapy report data collection period 2)

At the second data collection point, Roadmanjobs provides a picture of herself and a family member meeting at a particular place. This place is associated with pain as it used to be a place where they met with their ex-partner and then they broke up. However, they have learnt to reframe the experience:

> Last week I decided that I want to sort of reframe that area instead of it being unclear. That's where me and my ex used to sit. Oh, I'm so sad, just this and that I changed it to just a place where me and my sister could sit and talk about our secrets and things like that. So I kind of reframed it, which is something I tend to do on the ward as well. If I do see like any risk items like on the ward, I tend to. If there's a risk item, I tend to sort of reframe it. (Roadmanjobs, data collection period 2)

Photo 5: Roadmanjobs' picture of herself and a family member.

Superstar represents a picture of her dad's (recently deceased) favourite meal of sausages and mash, which reminds her of home and of her wish to achieve independence, through the cooking academy she has attended.

Photo 6: Favourite meal of Superstar's father.

(Superstar, data collection period 1)

Moreover, pets and animals seem to be a recurring theme that is identified as key to positive relationships. Animals are very important to Superstar, Bluedog, Roadmanjobs and Greenfrog. On the ward Superstar states:

> They're getting some guinea pigs coming in. Downstairs near the doctor's surgery. They've a lovely house. It's a white house and they made it fun. (Superstar, data collection period 1)

Summary

Ward residents often enter the ward under compulsory order and are likely to experience high levels of stress, as is reported for service users with a diagnosis of (borderline) personality disorder. The ward employs many ways to secure successful transition to the community and build self-esteem and self-worth through a hospital environment that provides a haven with personalised activities to ensure meaningful occupation. However, sometimes the ward can be experienced as unsettling with loud alarms and critical incident occurrences. Emphasis is placed in the ward on developing positive relationships and supporting service users to engage with systems outside the hospital. The interdisciplinary support with a focus on identifying positive recovery goals reinforced by positive relationship-based care provided on the ward are essential to the effective care provision and successful transition to the community. This approach is promoted in the Daffodil ward by focusing on shared decision making and the implementation of effective dialectical behaviour therapy.

Conclusions and implications for practice

This study shows the process of deinstitutionalisation within an institution. The service users resident in Daffodil ward are women in need of safety as they have a history of engaging in serious acts of self-harm before entering, most often, under compulsory admission. This underlines the need for the existence of the closed ward.

However, a closed ward can be a place where misuse of power and authority can occur – as the experiences of people with learning disabilities were stifled as reflected in the UK case of Winterbourne View (Department of Health, 2012). The introduction of experts by experience, who regularly visit the ward, promotes a culture of openness and transparency which enables the redistribution of power and reinforces the importance of listening to the user voice (Basset *et al.*, 2010).

The innovations represent a process in which transition back to the community is at the forefront of all planning. Dialectical behaviour therapy group and individual therapy (Lineham, 2011), reinforced by a practice of shared decision making, build on a strengths approach (Xie, 2013) seeking to give women the tools to recover (Zanarini *et al.*, 2010) and to reach the goals that

they themselves want to achieve. Thus, the process of deinstitutionalisation within an institution through the introduction of new innovations, alongside the implementation of the expert by experience programme deliver the support that women require.

This best practice in closed ward model presents an innovative frame that has the potential to positively influence the development of future hospital care. However, the small sample means that the evidence base has some limitations, and future research would need to be conducted to consider its overall effectiveness. However, the cumulative evidence base, building on the Springbank model, suggests that such a model has real implications for future practice and has the potential to provide a future framework for effective hospital-based care delivery for women with (borderline) personality disorder.

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