Personality Disorder Strategy Report Staff and Service User Focus Groups

Completed by Holly Cade and Jo Harris

March 2018 – March 2019

Contents

Personality Disorder Strategy Report – Introduction

NHS England have commissioned a strategic review of personality disorder (PD) specific low and medium secure inpatient services for men and women within the Yorkshire and Humber region as well as a mapping of available community provision. The key task of the strategic review will be make key recommendations as part of a 3-5 year strategic implementation plan with the aim to help develop best practice inpatient care and the development of community pathways that better meet the needs of service users. Crucial to the success of the strategic review is that we consult and gather views, and better understand the experiences, of all key stake holders including service users, staff and senior clinical leaders within such services.

We were tasked with gaining a better understanding of current practices and pathways through engagement and discussion with service users and staff, as well as to better understand the needs of service users and the workforce and to make some recommendations based on this work. There are 3 STP areas in Yorkshire and Humber and the first phase of the project focused on Humber Coast and Vale. These included

- Garrow House (women's step down service)
- Stockton Hall (2 wards - Medium secure male and female)
- Humber Centre (male medium secure)

To start with we met with the Strategy Project steering group and agreed a process and timescale for this work. We agreed a list of main themes that we wanted to cover in this work with both service users and staff. We drafted a participant information sheet as well as letters explaining the process and the project, and posters for the wards to advertise and distribute to each staff member and service user. These explained different ways that people could be involved, either through attending a pre-arranged focus group, or by attending a 1:1 semi structured interview. For each ward we offered 2 separate focus group opportunities for both staff and service users, as well as the 1:1 options. We kept the focus groups separate for staff and service users to enable everyone to feel comfortable speaking openly within the group. In general staff were happy to attend focus groups and this worked well. The majority of service users preferred to attend on a 1:1 basis. We offered an opportunity for staff to input into the process via a Survey Monkey Questionnaire after the focus groups had finished to capture anyone who had not been able to attend. We sent out paper copies to services so that service users could also input in this way.

The second phase of the project focused on 2 services which represented the low secure female PD perspective and that of low secure and medium secure male service users and staff within those services. These services were:

- Waterloo Manor (women's low secure including locked rehab)
- Cheswold Park (male low and medium secure)

Following feedback and consultation with the steering group and also with the people who attended the 2 workshops held at Sandal Rugby Club we decided to add in a few extra themes to the final 2 rounds of focus groups – these were around self harm, 1:1 observations and reducing restrictive practice.

The second phase of the project is also captured within the following narrative and quotes in order to complete this report so that it represent the perspectives of all of the staff and service user groups held across Yorkshire and Humber. The black font captures the initial wave of focus groups and the blue font captures the second phase.

Main themes– Service Users

Experience in community

The vast majority spoken to said that they had very little or no support in the community. Some said that they did have support but that the situation had reached such a level of crisis that they felt an admission was unavoidable and the only option, regardless of how much community support had of been available.

"People had to fight to get me in here"

"It couldn't have helped any differently"

In the second wave service users spoke about there being lots of stresses and not enough support. Some people said that they couldn't remember as it was such a long time ago. Most people talked about having very little support only a CPN, and no support out of hours, or having had many different people involved with no consistency. One person also spoke about the trauma she had experienced and said nothing could help apart from erasing that memory completely.

"Only thing that could have worked is something like hypnotherapy, to get rid of the trauma completely"

"My mum set up some counselling in the community which helped but then I went to prison"

Experience of different types of wards

Many service users had experienced different wards, some PD specific and some more general wards. Some had no experience at all of other wards and had come from prison. One main theme was that many people had been moved to a PD specific ward due to a lack of progression on mixed wards. The majority also felt that they were doing better on the PD specific ward as they were better understood.

"Staff trained to manage both, and not laughing at people – staff shouldn't laugh"

"It is a big change. I hope to get help to move on quicker than I did in high secure. People can live more easily in the community"

People felt that there was no support or treatment in prison. Others has many different experiences on different wards and didn't find it helpful to move around and have to start again with new staff and peer groups.

"Staff should be better trained to support people with Mental Illness and PD"

The differences between PD and mixed wards

Mixed wards - People felt that mixed wards were often very busy, unsettled and unpredictable. They often found it difficult to relate to others on the wards with different

diagnoses, and felt that there was a lot of stigma around their diagnosis especially from staff who perhaps weren't trained around personality disorder. Although some said that it was interesting to meet people with different mental health needs, and that this could be fun.

PD specific wards - People said that PD wards were often more settled, quieter wards and that people's presentation did not fluctuate as much, due to their illness being present all the time. People were more demanding of staff time. It could be unpredictable when people were self harming and this could be quite traumatizing to see. They said that people would copy each other and feel in competition with other patients to get staff time. They also said that staff understood them more and listened to them and were more tolerant of their needs and presentation. A clear majority said they would rather be on PD specific wards.

Mixed ward - "It is interesting being on a mixed ward learning how to comfort people"

PD ward - "the moment they feel heard, people recover"

Mixed ward - People felt that there was little understanding from staff about PD on a mixed ward, staff are learning as well.

PD ward - There are pros and cons of both – pros are that staff are more understanding on a PD ward about the diagnosis and about self harm, but the cons are that when you are ready to move on you are really settled and it can be hard on a really acute ward with people who are so unwell. It was felt to be more chaotic on acute wards with people's symptoms more pronounced. Some people talked about PD wards being viewed differently as PD is not classed as an illness. It was felt that the PD wards were less restrictive and the staff approach was different, however not much difference in the patient group and the bigger differences were between medium and low secure.

"No differences – every experience is unique - We are all just trying to make our way in the world"

"People think that self harm is just attention seeking, they have no real understanding"

Needs at admission

Service users felt that they needed lots of help, they were quite chaotic and relationships were difficult. People didn't understand their needs/diagnosis. There were concerns about length of stay. The majority felt that they did need an inpatient admission however this was to get over a crisis period and should have been for a short time, rather than the years that many had already spent in services.

"You see things in black and white so you need rules"

"After my first admission I had good support from community staff but bad accommodation and became homeless. I would be dead now without hospital"

It was identified that it is important to become stable on medication and to have Psychological interventions such as DBT in order to reduce self harming behaviors, to keep themselves and others safe. Social skills were identified as important to learn and to recover

with support from OT. DBT was mentioned the most as being part of people's needs at admission and for their recovery and was felt to be really helpful by most. Consistency of groups and therapy is important, that this feels like a safe space and that staff are all aware of it and can support them to practice the skills learned. Some felt that therapy and groups were constantly being revisited and that things were very repetitive especially when moving between services. The service users on one ward were critical of the staff and the input especially around Psychiatry (not getting medication they felt they should get) and OT (repetitive), however felt the Psychological groups and 1:1 support was worthwhile including music therapy, CBT, DBT and schema therapy.

"Need to keep myself safe and others safe"

"Cooking and gym – Sick of doing the same things"

"DBT has stripped me back and rebuilt me"

What is useful about admission?

Service users said that relationships were important as well as having good communication with staff. They said working together and being involved in decisions was really important, so working collaboratively. The type of staff was talked about – they needed to be down to earth, friendly, sharing a bit about them. They found that learning skills to manage their emotions and behaviour were important such as DBT and CAT with the opportunity to practice these on the ward on a regular basis. They said that if nursing staff were aware of these things then it enabled them to practice and this was more useful than just having the weekly 1:1 psychological sessions. Section 17 leave and activities were also important to everyone as long as the activities were things that they were interested in. They spoke about positive risk taking around section 17 leave and not having this stopped due to self-harm.

"I worked in the café, shop, gym and kitchens, the money paid for phone calls that I earned"

"If you get upset you can still go to sessions"

Having a case manager, a solicitor and advocacy support as well as support from family was identified. Doing voluntary work and having lots of leave and activities. Having a placement identified to move on to and to visit before discharge. Doing groups such as DBT was felt to be really helpful and taught people we spoke to a lot of skills that they felt would benefit them in the community. It was felt to be useful by many to be closer to home. Music was discussed as being really helpful as well as supporting each other, peer support and feeling part of a community.

"Everyone rapping together – fun and music is really helpful"

"We all support each other and feel part of a community here"

Contact with the community

People had contact with community through section 17 leave and family and friends visiting; however any contact with case managers, care coordinators, community teams etc. was extremely inconsistent. Many hadn't had contact with anyone from their home area for a long time, didn't know who these people were and had anxieties about moving on without any contact with wider services. They said that staff changed frequently. They said it would be useful to have a named person who they could build a relationship with whilst in services, and not feel that they had been "forgotten" about. A couple of people did have regular contact with someone consistently attending their meetings and this was found to be useful and was valued. Someone asked about the possibility of a Befriender, however said they had struggled to get this input as they couldn't find a community group that would provide this service into a secure service.

"My care coordinator changed when he was made redundant, but I know the new one from my past inpatient admission"

"It would be helpful to have a CPN, it feels that they would be a friend, someone who could help. I would like that contact"

Community contact was very inconsistent and many didn't know who their care coordinator was or hadn't seen them for a long time. Some had contact with probation and others had more contact with case managers and a more positive experience of this, helping them develop links in the community.

 "My case manager is helping me to make links with self harm groups in the community"

Helpful experiences

Service users spoke about a well-run ward with boundaries and structures in place. They spoke about the size of the ward being smaller and with enough staff to recognise when someone was becoming unwell. Staff consistency and responsiveness was noted to be important and a structured but relaxed environment. They said when they became settled on the ward this was when they felt the benefits and they would become engaged with staff, trust staff and have better relationships as well as learning to deal with their emotions. Seclusion being used a lot less was a positive thing. Access to work opportunities and meaningful activities were important and a real positive. People stated that a good way to distract themselves from their feelings was to be able to engage in these even when feeling upset and that this would help them to feel "normal". Having a laugh was a really positive thing for people and the informal peer support, the morale of the ward.

"My family worry less now I am here"

"Staff are helpful, they see when I am going downhill and they come to me"

Service users found it helpful to make friendships in hospital among people who had common experiences and could understand what they were going through and found 1:1 sessions helpful when feeling low. Where people had been in the same hospital for a while then they felt able to open up to staff and said that after a while this starts to change your mindset. There were also discussions around how hard it is to build up relationships again when you move, both with staff and peers. Lots of discussions around how helpful good staff are, how they go out of their way for service users and are open and honest. Regular section 17 leave was felt to be helpful as well as DBT, Recovery College and practical skills like cooking, learning DIY, plastering and other life skills.

 "I wouldn't be here today if it wasn't for services"

"Staff are good most of the time, they go out of their way for you, but relationships can be hard"

"It saved my life coming into hospital"

Unhelpful experiences

Service users spoke about when patients were pushing boundaries to be in control they found this hard. They also struggled when things were unpredictable and with any inconsistencies, particularly with staffing, staff approaches and unfamiliar staff. The rules on the wards being unclear was difficult, or if there were 2 sides of a ward with different rules and they could see people having things that they weren't allowed. They found big wards much more difficult and said there should be a maximum of 12 on any ward. Boredom and a lack of facilities was a negative experience, or when activities were cancelled. They talked about repetition, having to do the same groups over and over again in different settings and this contributing to their long length of stay, and the frustrations around this.

"Being in hospital doesn't make you feel happy; there should be a time limit on a hospital stay"

"If people self harm and come out on the ward, watching and seeing their distress is distressing"

"I keep asking for more leave, I have done what they ask but I still get no leave"

Being assaulted and restrained or seeing this happen to others was identified as incredibly difficult and traumatic. The wards are small areas with lots of people who are unwell which doesn't help. When people self harm this causes a distressing environment which can act as a trigger for others. The ward can be a frightening place when people are fighting. Due to the environment it can be difficult to have a quiet space which is hard. Staffing levels can be really low especially at night. On the male wards there were not always male staff available which could lead to patients feeling they need to support the female staff and restrain other patients which is unsafe. Service users felt that staff can have a bad attitude and talk down to patients at times, although many others are good. It isn't helpful when people get mixed

messages from staff and they treat people differently. It was also discussed how it takes time to build up trust with staff and then they leave.

"Staff talking down to you gets your back up"

"It's not good when patients are keeping the female staff safe"

"It is hard when you don't get on with your peers, or when you complain and nothing happens"

How is Self Harm approached?

It was felt to be unhelpful when things are overly punitive, such as if you self harm and lose leave or your TV, as these things can be helpful to take peoples minds off what is going on in their head. Having items that haven't been used for self harming removed from the room was not thought to be helpful. Others felt that self harm is dealt with in a helpful way and not broadcast to the rest of the ward. Some staff were supportive but not all. People keep self harm to themselves in general on one ward which was felt to be good. One patient had tried safe cutting previously but it didn't work for them. It was described on one ward how they felt that staff are not accessible and sit in the office and that they feel like they receive more support from their peers. It was also felt that staff turnover was high so it felt easier to trust peers who are really supportive of each other rather than new staff members.

"Not helpful – clothes but not TV – that is needed for support.- distracted. Take stuff out of your room – not helpful"

"Yeah it is helpful – quite confidential, not broadcast"

"staff don't really care, they are in the office and I would rather go to one of my friends for support, at least they are always there"

What are the thoughts around the helpfulness of 1:1 Observations?

Some felt that 1:1 observations should never be used they are not nice. Others felt that they could be helpful and might be needed sometimes but should only be for short time. Staff need to think hard about why they are putting someone on a 1:1, is it just because they don't know the person? 1:1's are not helpful as people need space and 10 minute observations could help prevent escalation and seclusion.

"1:1 obs are horrible; it doesn't help to have someone following you around all the time"

"Observations are not used properly to interact with patients but just to observe them, it shouldn't be like that"

Reducing Restrictive Practice

We spoke about the impact of Reducing Restrictive Practice. This was generally seen as a positive thing among the service users however some issues were raised around restrictions not being relaxed as they should be. There are now some things are allowed such as e-

cigarettes which was a positive outcome for many. Searches were supposed to be random but actually seemed to happen frequently. People felt that more could be done in terms of reducing restrictions – on a low secure ward that was part of a bigger hospital with medium secure it was felt that they were still under medium secure restrictions. There were discussions around technology and this not becoming any less restrictive and that progress is very slow.

"Disagree with restrictions – tea, coffee – not get a cup of tea hot water flask"

"Need to be more productive, changes too slow it feels like we are not making any progress"

Planning a successful discharge

Service users talked about having a permanent place to go that is peaceful, stable and safe. The right medication was important and support with this from a psychiatrist. They talked about stable tailored support from someone who visits regularly and someone who cares, as well as access to staff that understand them. The discharge should be planned well and include positive risk taking. There should be continuity of support and contact with people on the ward and it should be possible to keep the structure and activities from the ward. There should be access to a case manager and someone in the community at the earliest time possible to build those relationships while still in hospital. Family should also be involved if this is what the individual wants. Another thing was around having support to use skills that they had learnt in hospital such as DBT skills, as well as help with benefits and getting a job or going to college.

"More support to be able to get help all the time when I get my own place"

"I have been here too long; it feels like I will never get out. I would like to move out of hospital for a better quality of life"

"I would like an outreach nurse that understands me"

"I would like a night job when it is quiet, peaceful and not lots of people around"

It was important to have a staff member to talk to on discharge, and somewhere to go like a job or college or a day center. There should be regular staff and good housing. Staff need to listen to the person and what they want when they leave and come to a mutual agreement as the patient knows best. There needs to be a care package in place so everyone knows who is involved after discharge and with proper follow up to meet with the person regularly on an individual level as it is a big step for many people. It was felt to be helpful to get to know staff in the community first before stepping down. Help to remember medication was important, support with finding a job and keeping busy, volunteering. There should be a self-harm hotline for nights, with an emergency number for mental health and a call out system. Some people talked about having a visual plan with the next steps in place to be able to clearly see the plans for discharge, timescales etc. A slow transition was identified by some as being important to them.

"18 times discharged – I was homeless – no housing provided"

"Follow up – meet with someone regularly at an individual level – it will be a shock to the system"

Magic Wand

The final question we asked was what they wanted services for people with a PD diagnosis to look like if they had a magic wand. They wanted there to be more space on the ward but smaller number of beds (8-12). They wanted friendly staff that are funny, down to earth, responsive and that share stories about themselves and join in. Staff that are respectful and stick to rules and boundaries and enough staff were also important to people. There would be lots of activities and section 17 leave, plenty of things to do so that they don't get bored and these things should always be available and not get cancelled. They would know what the transition plan is – assessment and stabilisation and then discharge into community with better support so that they are not in hospital too long. Some talked about having a settled area and a more intensive area so that you don't have to see people distressed and self harming when they are more settled. People also talked about the importance of the Recovery College, both while in services and when they go into the community.

"Someone who helps and doesn't say 'in 2 minutes'"

"It doesn't matter which staff they are – as long as they are there"

"Don't hang onto people too long. They get dependent on hospital and do silly things to jeopardise it for themselves close to discharge"

"It gets people out quicker if it is an intensive program rather than just Psychology once a week. Use the whole week!"

The doctors would listen to patients more. There would better community support like CAMHS. It should be down to the person though as they need to be ready to engage. More activities to do would improve the service instead of sitting staring at 4 walls. OT activities should be on more and more distractions to stop people sitting ruminating such as on ward activities. There should be more crisis services in the community. There should also be more internet available on the wards. The food should be better as well, importance of different diets, opportunities for self catering. More outside activities were important to people. Wards should be more homely and staff should be more welcoming and available.

"The doctors should listen to patients more they don't always know best!"

"Staff should be more welcoming and there to talk to when you need to"

"The food really needs to get better around here, we should get the same food as the staff"

Recommendations from Service User focus groups

- There should be better support in the community when people are struggling or in crisis to prevent people coming into hospital.

- If there is a need for a hospital admission then they should be supported through this process to ensure any admission is as short as possible with continuity of staffing and care. Treatment should be in one hospital with no one moved around unnecessarily as it is difficult to build up relationship with new staff teams and peers.

- Treatment should be as close to home as possible unless this is not wanted for individual reasons and then there should be choice and the individual should be listened to where possible.

- Wards should be PD specific where possible.

- Admission should be for assessment and formulation and then therapeutic interventions should take place in the community.

- Wards should be smaller (8-12 patients).

- Peer support, morale, fun and the use of music were identified as positive aspects that need nurturing and developing so that people can feel supported and have positive experiences of an inpatient admission where possible.

- The ward environment should be settled with clear structure and boundaries so that people know what to expect and feel safe. This includes a consistent, well trained and well led staff team that can maintain these boundaries and develop strong therapeutic relationships with service users. 1:1 time should be planned and agreed together and rules and agreements transparent and adhered to.

- Activities and therapeutic interventions should be tailored to the individual, always take place and involve positive risk taking, such as not cancelling leave or activities due to self-harm. Consistency of groups and therapy is important, that this feels like a safe space and that staff are all aware of it and can support them to practice the skills learned. Therapy and groups should not be constantly revisited when moving between services, so a portfolio of treatment should go with the service user, with the emphasis being on practicing learned skills rather than repeating the groups in order to keep and further develop those skills.

- Practical life skills and vocational skills should be available so that service users leave hospital with skills they can use in the community.

- Self harm should be dealt with in a supportive and non-punitive way, with any increased observation levels kept to the minimum time needed to manage that risk if at all, and risk items not removed unnecessarily and taking a collaborative approach.

- Restrictions should be further reduced where possible, especially around technology to make the transitions easier. If a hospital has different levels of security then the differences in restrictions should be clear. This should be transparent and communicated well throughout the service.

- There should be better and more consistent input from community teams/case managers/care coordinators. They should visit more consistently to allow a relationship to develop with the service user so that they don't feel forgotten and this in turn means they have a contact in the community and moving on is less anxiety provoking.

- Discharge should be thought about and planned from admission so that people are involved and have choices and a clear idea of their pathway from the start. They should be fully involved in this process in order to take ownership of their recovery. A plan should be identified with each individual person around discharge pathways in an appropriate accessible format.

- After discharge there should be the option of ongoing contact with the ward through the Recovery College.

- In the community there should be stable and consistent staffing from psychologically trained and informed staff who understands them and their needs, and who can continue to practice and support skills learned in services as well as continuing with interventions that started in hospital.

- There should be a clear structure in the community for service users, this could range from attending college, voluntary or paid work, or many people spoke about the old day centres as having been a positive experience with nothing now to fill that gap.

Main themes – staff

Previous experience

There was a big mix of experience; some had no prior experience at all, whereas others had extensive experience of lots of different types of wards. Some came straight from nurse training, others from university or it was their first job. Some were there to get experience before going on to different types of training. There were some bank and agency members of staff as well as permanent staff members. There was a mix of disciplines consulted with as part of this work, mainly nurses and support workers however we also spoke with Psychologists, Social Workers, Occupational Therapists, Psychiatrists and other health professionals. The same differences in experience existed in all services visited.

What are the differences between PD specific and mixed wards?

PD wards - People talked about there being more demands on staff time in PD specific wards and about structure being important. The environment is more stable and it is possible to have more 1:1 conversations with patients. Staff talked about consistency being more important as well as boundaries. They also talked about the need to be honest and open and transparent with service users.

Mixed wards – Staff said it was a quicker change of pace, there were less opportunities for staff training and people with mental illness were more vulnerable to bullying from PD patients so best to keep them separate.

"Communication needs to be the same from all staff. The patients know what is what. You need to be open and honest, be there when you say, have structure, consistency and time for people"

The differences identified were around boundaries and relational security, and the differences in the team dynamics.
Mixed/Mental Illness wards – Staff felt that they were able to work more flexibly; especially with leave as it was possible to do things in a more impromptu way. People felt that mixed wards were very difficult as patients would pick up on the inconsistency and there would be too much going on. Others said that the mix of patients made it easier as there was less stigma attached. OT's felt that from their perspective there was no difference as to how they would approach a patient with PD, however the nurses would have a different approach depending on diagnosis, for example having a more boundaried approach. Some thought a mixed ward would be beneficial as it would prevent service users and staff thinking they are special.
PD wards - More of a need for consistency. The different staff approach was felt to be important such as being more consistent, less flexible, building boundaries, thinking about personal issues.
 "Cannot deviate from the plan – you'll pay the consequences"
"Very difficult – with mixed wards, although people don't fit nicely into boxes"

"You need to know what people present with – what to expect on different wards. It is better mixed otherwise staff and service users see themselves as special"

"Staff are strong and compassionate on the MI ward, and strong and rude on the PD ward!"

Why work in PD specific wards?

Many staff told us that they had not chosen to work in this environment but had joined a larger hospital and then been placed on that ward. Their initial reaction was to cry, and that they were not happy, but that "it draws you in", you learn about yourself as well as others and the majority now enjoyed it and would't want to leave. Some had chosen to work there and said it was the challenge that they wanted, that it suited them and that they enjoyed working with this client group. Other said that they enjoyed nursing people with long term conditions. Staff talked about there being more opportunities for training, for delivering and practicing therapies, and developing transferable skills on the PD wards.

"I found my comfort zone on this ward. I am 50 and want to stay here now. I know all the patients and their families. They can be challenging and also very charming. They are all just men in the end. I get on well with them and they are happy unless their needs are not being met. They all like to be important but you all need to keep boundaries"

"If someone gives you a sweet, it is never just a sweet. Once you know that it is easy"

Discussions were had about rebranding services for women as trauma focused rather than PD or mental illness. This was felt to be more helpful as things can get confusing. Staff talked about how they really enjoy working with this client group and find it very fulfilling. It suits some people having that relational security and boundaried approach where the approach is firm but fair, and once rapport has been built it is about teaching life skills. Others discussed burning out on PD wards and needing to move away from that. Many didn't want to work on PD ward initially due to stigma and hearing stories; however once they worked there they enjoyed the experience. It was discussed that it is like "Marmite" – you either love it or hate it. It was discussed in detail about the reasons for working on each ward, some was out of choice whereas other people were allocated a ward. Many were frightened initially usually based on stories about chaos, self harm, trauma etc. Many found this really interesting and loved the experience, finding the MI cohort of patients more difficult due to people being so "poorly", others found it traumatizing and heartbreaking on the PD wards and found that more difficult.

"DSPD – the dark side"

"Prefer the PD wards; it fits with my approach, firm but fair"

"Didn't want to work on PD ward but then enjoyed it, although can be traumatic"

"I have a soft spot for PD, although when I started on this ward it was "bouncing" – a bit of a shock!"

"Frightening stories, chaos initially – not fully understanding it – wanting to find out why?"

"Interesting but heartbreaking - Your personality is disordered"

Main challenges for working with this client group

Staff spoke about service user's lack of or fluctuating motivation and engagement as being one of the main challenges alongside maintaining boundaries and consistency. They spoke about the pressure that they often feel to put service users on 1:1 observations and how patients can "up the ante" to try to get put on these. They also spoke about service users "jealousy" when others are perceived to get more attention than them. Self harm was a challenge for staff at times and some struggled more with this than others. They said that the patient mix and dynamics on the ward was difficult but this often changed when people moved on or a there was a new admission. Family dynamics could be hard, and a destabilising factor at times and hospital can be a protective factor for some. They spoke about the need for family therapy. They also spoke about staffing being difficult, struggling to recruit and retain staff due to the stigma.

"It is frustrating when we organise things and put everything in place for someone when they have asked for it and then they refuse to engage, or don't get out of bed, or have lost their motivation"

"Patients saying 'I don't want to do it but……' about self harm"

"It is a busy ward, everyone wants their needs met at the same time, but it is how you word it. You need to pay attention to language. I was told about this in my induction"

The challenges identified were around the client group being an emotionally challenging one and staff not always being supported well. It can also be difficult to facilitate things on the ward as motivation can be very poor. People spoke about wanting to understand why the patients behaved or responded in a certain way, trying to gain an understanding of what is behind the behavior. They felt that patients responded to that better – "how I respond affects how you respond". They felt that challenges existed around external factors that were out of the control of staff or of the patient themselves such as getting a text message and this leading to an immediate change in presentation such as self harm. This could be in relation to something that happened years ago and suddenly being triggered by social dynamics. People spoke about finding it difficult to switch off and finding it draining, "soaking up all the emotions" and taking things home with them.
"It can be all or nothing on the PD ward, and crisis feeds crisis"
 "Unexpected cutting, ligature, head banging – what is the trigger?"
"See people doing well and then something happens and it all goes wrong"

What makes it "Specialist"?

The therapies that are on offer were felt to be what makes it specialist, lots of treatment and therapies such as DBT, CBT and CAT. The staffing ratio and smaller wards also makes it different to other wards. The staff have access to specialist training around boundaries and self harm and having ongoing support. The activities that are on offer were also spoke about. Staff talked about there being more staff time for 1:1 sessions and using very little

seclusion. Staff talked about using a specific model and formulation to think about and work with patients.

"More 1:1 sessions to talk and calm people down. They like and value time to talk with staff"

"I didn't know we were "Specialist"

"People like to choose who they want to talk to – they will talk to some staff and not others"

"Other areas are specialist too"

The staff approach was felt to be what makes the PD wards different and potentially specialist. It was felt on one ward that the focus of the organisation and wider in terms of policy was on LD with the Transforming Care Agenda and that PD was not recognised as specialist any more. The model of care which includes formulation, DBT, schema therapy and CBT and different ways of working do mean that the PD teams work in a more specialist way. Some felt that as many of the patients with a PD diagnosis presented with similar traits or needs then the team were able to respond to them in a certain way ensuring a consistent approach. Some felt the language around specialism was not helpful as it made people feel special or superior. It was also felt on one ward that PD should change its name and be marketed differently to get away from the negative stereotypes and fear that is created around PD.

"We are not thought of as specialist the focus is on LD"

"Our teams work differently on the PD wards and with a different approach so yes we are specialist"

"People who attend DBT feel special – use it as a way to not engage in other things"
"Specialist wards are special not specialized. There is nothing different – no special training or induction"

How is self-harm managed, is it effective?
Staff felt that the level of self-harm and suicide ideation had decreased on one ward. Verbal de-escalation is used to good effect as well as individual 1:1 sessions with service users. Self harm can often have a domino effect with this client group with secondary incidents happening with other service users after someone has self harmed which is not helpful. The policy is to try to manage people within the hospital and minimize A&E visits where possible. There are RGN's starting who are currently on induction so that feels like a positive advancement and will be really helpful as there will be one on each pathway. A new policy on batteries has been implemented which has also cut down on A&E visits so being managed much better. Some wards held support sessions; providing people with support and consequences and positive risk taking, but felt that the induction could be better – they spoke about self harm on the induction but it was "gentle, not to put people off" so it didn't prepare people for the reality of the ward. Some wards would be restrictive when someone self harms and remove the risk items, although tried to reintroduce the item as soon as the

crisis abates. Approaches seemed to vary even within the same hospital depending on the ward.

"You have to be unflappable on the front but you know you are peddling underneath"

"People see someone else self harming and they then want that attention and it is really not helpful"

"We used to be at A&E all the time and now it is much better, levels of self harm have gone down"

Do you use 1:1 observations?

1:1 observations are used but only when necessary and can be useful if used for the shortest time possible. Some had an issue with 1:1 observations as a way to manage risk and felt that 1:1 conversations are a better way to manage a crisis situation as the observation doesn't help solve the issue or address what is happening for the service user. These sessions can build rapport and trust and enable them to take responsibility and move on with some independence. It was felt that once you get someone on a 1:1 then it is very difficult to get them off observations again, and felt that shorter observations were more beneficial all round. Some would not use 1:1 observations despite patients attempting to "up the ante" threatening to self harm.

"Put me on 1:1s or else you will see what I will do – ok then we will see"

"They can keep people safe but they don't really achieve much else, it is better to use shorter obs and actually engage with people meaningfully"

"People come on line of sight observations when they are first admitted, I don't think these obs help and it makes people more dependent on staff and takes staff away from other duties like taking people out on leave. When obs are reduced at first the risk always increases too"

What has been the impact of Reducing Restrictive Practice?

Reducing restrictive practices is a big challenge due to weighing up least restrictive practice and safety as it doesn't fit with the model of care. Staff said that if you reduce the boundaries it can make people feel less safe, both staff and service users. They also said that different rules for different people is hard because everyone wants to be treated the same. This was felt to have gone too far with all restrictions being reduced. The general feeling was that it was really hard with this initiative coming in especially on the PD wards as it was making things unsafe, increasing the level of contraband items on the ward and hard for patients as they needed the boundaries of the restrictions at times, even if they hated them. Others felt that there were positives and negatives around restrictions and reducing them. Some felt that this was more difficult for people with PD as it is hard to adjust, although others felt that this has helped them to work with patients better by being able to relax some rules and give patients a bit more responsibility and ownership. Restrictions could

often be trigger points for people such as not being able to make a drink, or having to enforce bed times so many thought that incidents had decreased as a result.

"At home we would make a drink at night if we wanted to. This isn't a hotel, there needs to be more focus on community"

"When I worked in rehab it was scary as all the restrictions were gone. I had to adjust"

"The best way for a PD patient to get exactly what they want"

"It is a buzz word at the moment, the patients love it"

"It also makes it harder to safeguard people, it makes them more vulnerable"

"Unnerving and scary for staff"

"Patient with PD, they hate boundaries but need them – there is chaos if no boundaries"

"Positive – brought services into modern times"

Staff support

Staff support varied depending on which ward we spoke to. People had a lot to say about this. Some had extensive support both formal and informal which included things like staff supervision both 1:1 and group, reflective practice, debriefing after each shift or after serious incidents, case formulation, team work was important and the informal peer support was highly valued. Some spoke about community meetings being for everyone not just patients and felt that they found out more at community meetings than they did at staff meetings. It was identified that there are not many leaders with PD specific experience so hard for some to get appropriate supervision. Staff felt where they were involved in an incident they were well supported and involved in decisions about how this was managed. People also had clinical group supervision, traditional supervision, flash supervision which you can access at any time from anyone which was felt to be more responsive to staff need. Others felt they had little or no formal support, didn't know when they last had any supervision at all, but felt that the informal peer support was very good.

"The team supports the team"

"Debriefs haven't happened for a long time now. Not enough emphasis is placed on the benefit of debrief and when the psychologist left they stopped"

"Reflective practice is helpful and insightful, you learn how best to approach problems"

"We used to have 2 psychotherapists to support from the Portman Clinic. It was amazing! It stopped for the wrong reasons - costs and disagreement from management with the psycho-dynamic model"

Support for staff was felt to be hit and miss. There was some reflective practice sessions and debriefs after incidents but this did not always happen. One ward felt that the resource for formulation meetings didn't exist and this was an area that was hugely lacking. They also felt that they only had supervision once every 3 months and that this was not good enough. However another ward felt that the formulation, team discussions and general supervision was really beneficial. Having Reflective practice sessions where the team can focus on one

patient and really understand the person was talked about as being a really invaluable approach. It was felt that there should be more choice for staff around the length of shifts as long days were really hard for some, especially considering the stresses of working on a PD ward.

"Formulation meetings are hugely lacking – but there are no resources to do those"

"In the past there was no debriefing at all, we went from the frying pan, into the fire"

"After incidents the service users get debrief as well, self-care is so important"

Recruitment and retention

People talked about the stigma of the PD diagnosis as being perceived as dangerous. They also said that people being "untreatable" was a challenge. No day is ever the same and motivation and self harm were real challenges, and that all of these things affect recruitment and retention, some positively and some negatively. There was an acknowledgement that PD wards have a bad name and are therefore difficult to recruit to. They said there were problems with retention when people were recruited "as a job" rather than because they were passionate about the challenges of the client group and that there needed to be more awareness of different types of PD to inform choice of where to learn and work and what to expect. More information and training on induction was thought to be useful especially in large hospitals with many different wards where the induction was generic and then you were placed on the PD ward but with no specialist training. They also spoke about "burnout" and staff becoming disillusioned as a result of working with people with lifelong conditions and not seeing people "recover".

"Anyone who applies for a job gets it"

"You either love it or you hate it"

"Give it a chance, if you don't like it after 3 months you can move – 95% will stay"

"Be nice to each other and look out for each other"

Staff talked about how it was easy to get staff through the door but not necessarily the right staff – many staff recruited are young and inexperienced. Other wards had the same staff for years and stated that the new staff didn't seem to stay around for long before going to do bank or shift work.

Another ward said that they had no issues; they had the same staff for years. New staff don't stay long – go bank, shift work. It was suggested that doing some Psychometrics as part of the recruitment process would be useful as it would ensure that only staff with the right values etc. would get through. Also there were no clinical staff or service users on interview panels which would also help to ensure the right kind of staff were recruited. There was a high turnover on the medium secure admissions ward due to high levels of violence, staff focusing on risk reduction and not having the time to train and support staff. Staff who went on to the other wards would receive better training and then they don't want to move to the more unsettled wards. It was discussed how anxiety is created at

induction with a big point in the interview process about "difficult" service users. Some discussed how it was important to be more open and transparent to people applying about what they should expect as otherwise people start and then leave quickly. People spoke about staff not choosing to work on the PD wards on overtime or they do overtime on a different ward to normal. Some people have a good understanding and are robust and resilient so they stay around; others find it too stressful and can burn out quickly.

"No one wants to go on to that ward, but why would you?"

"We need staff that have a bit of something about them, a bit of experience"

"There is a bigger burn out rate – patient latch onto specific staff members – non-stop; it is constant which is exhausting, really difficult"

"When it is unsettled it affects everyone – I person struggles then everyone else suffers"

Training needs

In general people felt like they had a lot of opportunities for training. They felt well trained and some of the things they found most useful were: CAT training, KUF training, DBT awareness, PMVA, Boundaries training, self-harm awareness, problem solving skills, resilience training, substance misuse, PBS, collaborative risk training. People also talked about induction being good and comprehensive for those working in a specific PD service, but where they were part of a wider hospital they often had a generic induction and nothing PD specific. The feedback was that this could be a lot better.

"In terms of wider training robust supervision from the Portman clinic could help you understand things more and give your work more meaning"

"I am old school and learnt from experience. New staff are like deer's in headlights"

One ward discussed the introduction of PD training which is a full day course for all staff which has been recently introduced. This is great and well needed. They are also developing training on PBS and new PBS plans which are collaborative and easy read and this is really helpful. KUF training is great and they want to make it open to all. Other wards also felt that this should be a good starting point for staff, as well as having a brief overview of DBT in order to support people with the skills they were learning in Psychology sessions. There are also short sessions for staff around schema therapy and psychology sessions in one service. There are mini slots in the induction for all which is great, so everyone knows a bit about what is on offer and the approach. One service had sent a group of staff on KUF. This was only small numbers and targeted on one ward but it was felt that everyone works better having had that training. Other training identified was Self-harm training, Mental Health First Aid training, Asist training and PD therapeutic community training.

"Staff learn about psychology and different sessions on induction, it's really helpful"

"KUF training should be available for everyone. This is what is being aimed for"

Unhelpful admissions

Where admissions had not been helpful this was often around the person not being suitable for the service or it being the wrong time for them. This was sometimes down to inaccurate assessment or gatekeeping or the service user not being ready to engage. Sometimes things could break down if they were not feeling contained, a very unsettled ward, or learning negative coping strategies from each other. People talked about service users getting "stuck" on 1:1 observations and not being able to take them off these without the risk increasing to an unmanageable level. When ready to step down service users could "sabotage" their moving on, or the process can take too long and they lose hope and move backwards. Things could break down when self harm or aggression becomes too much for the service to manage safely. It was identified that there is a need for better transitions in general.

"It is an unhelpful admission when they don't want to be here and don't engage. During the settling in period if their needs aren't met, they don't trust or they struggle to make a relationship with those staff and then feel let down"

"if someone spends a lot of time in the system then stepping down is terrifying. People can then deteriorate or sabotage discharge if it is too fast. So go slow and steady"

One ward discussed a case study whereby they admitted someone from prison for assessment. This was not successful, the patient smuggled drugs and was unwilling to engage so there was very little that they could do. They spoke about there being different levels of PD, there is a pressure to move people on but sometimes people need more time. Some people like to be in hospital for lots of reasons and one reason is money as it is a lucrative place to be. They felt that the prison service doesn't help and more should be done to support people in prison instead of admitting to hospital. Some patients needed to be in hospital but now need the community and are stuck as there are no community placements for them which is really detrimental to them and to the ward as a whole as people lose hope the more it drags on. Sometimes a lot of the Psychological work could be done in the community. They talked about timescales being important. Patients can feel forced to engage and then this doesn't work as they need to take ownership. Sometimes there is too much pressure to move on quickly.

Another case study discussed was a patient who was a risk to their peers and nearly died. They were in segregation on 1:1 for long period of time and it took a long time for them to move on from this. They were offered extra sessions with a special timetable. They then had a further deterioration in mental health and decided this wasn't for them, requesting a sideways move.

Another case was discussed where there were lots of incidents. External people who decide on how/when/where people move on thought that she should move hospitals. This culminated in a lot of incidents as the patient didn't want to move on. Stated they will die if they move on.

23

Other patients just get stuck, mainly as they have lost touch with the community and become institutionalised. They feel like this is their home and community services are not there. Even when they believe they want to move on this is often much harder for them than they anticipate. They do the best that they can but often there is nowhere else suitable as their high risks remain. Many of them have risks are around drugs or alcohol, substance misuse, and they have done drug and alcohol work but often say that they will go straight back on to it.

Another ward felt that in the past they held on to people for too long, perhaps when the risks were too high but they didn't want to admit defeat by sending them up a level of security, however this has changed and they don't hold people back any more. They do still often manage difficult cases above their security level and they invest a lot and exhaust all the options trying to get people over the crisis point.

"We don't like to admit failure, you invest in someone and want to keep trying with them to make things work, but sometimes it is just not the right time for them"

"Many of the risks around drugs or alcohol are still there – they look you in the face and say first chance they get they will drink again"

"The system fails them, there is nowhere for them to go, lack of appropriate resources in community – varies from area to area – post code"

"Public services don't want "risky" patients back in the community"

Helpful admissions

When people are ready for the admission and they are ready and willing to engage then admissions are much more helpful. People spoke about it being the right time, about service users using a combination of therapies to think in different ways and then applying it to themselves. Staff spoke about section 17 leave being a real positive as it makes people happy, keeps them busy and shows real tangible progress. When service users feel safe and contained then they are able to engage better and more productively. Staff spoke about the right balance between restrictive and least restrictive being important as well as a collaborative risk assessment that is dynamic and individual and that allows for positive risk taking at the persons own pace. Some staff spoke about being open and honest, the value of apologising to patients if things don't always work out how they have told them it will. Good relationships and communication, as well as empowering the service user to take ownership of their recovery is key. Keeping service users busy and engaged with activities and leave and making these meaningful are all helpful. There is also a need to pay attention to family involvement and to support with this. Involvement and choice in moving on was another thing that could help with this part of the pathway, and moving at the patients pace.

"When someone is ready to move on something just clicks inside them"

"Give people a chance to rant and get things off their chest"

When people are ready to engage then things go well for them, something clicks and they are motivated to do Psychology or anything that is provided. People discussed that when people do well there are lots of things that contribute, easier family situation, perhaps trying a different treatment, finding their identity or just growing up, but the main thing is their attitude towards the admission, and then everything falls into place for them.

"Some get wonderful help – lots of support for FOLS – great if it works"

"It is all to do with the person and them being ready, motivated, sticking to a plan"

"When people are ready to move on they will do"

Planning a successful discharge

Staff talked about the importance of things like having an assessment in hospital but treatment in the community. As such there would need to be PD specialists in the community, preparing people from admission, relapse support that is forensic in the community to support people with higher levels of need and to prevent readmission, community support workers so that support could be more intensive, as well as the ability to stay connected to the ward, perhaps through the recovery college. This would help to retain the routine and structure from the ward when out in the community. Consistent staffing in the community was thought to be important and someone for service users to talk to when needed as well as somewhere for them to go to. They spoke about the importance of ongoing psychological input as well as having crisis plans, and the patient being involved in their transition plans, having options and choices and it being a slow and steady discharge. Promoting independence was identified as being important in order to promote and plan for discharge.

"Ask yourself what are we doing for this person"

"What next? A lot have nothing to go out to. If they do, channel into it e.g. family, jobs, and activities"

"Involve people, give options and choice"

There was a lot of discussion around finding some occupation and something to do for the service user in the community, this included things like day center's as this provided somewhere for people to go to. Housing was highlighted as being really important and that this was in a nice area. Staff talked about the structure that patients experience in hospital not being sustainable in the community so we are setting people up to fail as they won't have such a timetable in the community making the transition more difficult. When people are discharged from a prison section then they often end up in probation approved premises which are really unsuitable and expose them to the chaos of others. When they are in hospital they get no concept of money or reality as they have a lot of disposable income and spend it on trainers and taxis which is not realistic in the community. They spoke about the length of time that it takes as being really difficult as it can take 6 months or a year to discharge someone when they are ready to go straight away.

25

Someone spoke about the Brokerage or panel system not being helpful as it removes the professional's ability to source a package of care that you know they need. Many felt there were no links with the community and that hospital and community were two totally different things with no consistency or pathway through. This could be followed through with staffing from hospital going into community for a month to continue some support. There were no rehab places in the area of one of the services and no new places opening up which felt like there were no good options for people moving on. There were no places with psychology or wrap around services so better links need to be in place and included with a more gradual discharge. They felt that endings are not done well and patients can feel "booted" out or abandoned. Sometimes people just go and there is no time for endings. People's index offences can be seen in isolation which can prevent them moving on - "ooh they look horrific on paper"

There needs to be a good routine in the community to prevent them getting lonely or bored with no structure, and a good support network needs to be in place as they may only see community team infrequently. Family and friends as well as hobbies, college and things like the gym are important. And they thought that it made no sense that the community teams that don't know the person find them a placement, not the team that knows them well.

"Even in our life we need that finding our feet time"

"Stuck – passed from service to service – institutionalized"

"We need to get a lot better at this – don't think we plan discharge from admission"

Connections with community

Similar to the service user section on this question contact seemed to be very inconsistent. Many felt that this was not good, that there were not enough resources and that it would be better if community teams, case managers etc. could attend more often. They felt that links could be better especially if funding is involved, but many only seem to get involved if there are problems during admission. It is good to have forensic support in the community with small caseloads. Involvement from CPN's thought to be crucial when stepping down.

Connections with the community were mostly sporadic and inconsistent. This depended on the area that the patient was from but often had very little input.

"So hit and miss area to area"

"Patients make comment about it - Some good and some very poor"

"Not a reflection of the individual – but of the system"

"When I worked in community I linked well into the wards. Now on the wards that link has gone"

"We link out to community – groups etc. But community does not come in"

Magic Wand

People talked about having a step down supported accommodation type model that could support patients with the same staff that they were used to, as well as being able to come

back for groups and maintain some of the structure they were used to. Lots of people said smaller wards and bigger space. 12 beds was felt to be a good size. When the risks were removed/ minimized then support should be in the community with professional support. Psychologically minded staff were felt to be important with a consistent staff team that were passionate and enthusiastic about working with the client group. Staff felt that there should be more things to do, hands on real job skills like DIY, painting and decorating, things that are practical and transferable to real life, to the community and to getting a job. A strong team with good leadership would be important. In an ideal world more resources and more activities were identified as well as more involvement from community.

"A big house just like Garrow House but with more space and with a pathway on site"

"It's not the patient that needs to change it is the system"

"If you understand the game it is a great job to do"

"A step no matter how small is still a step…so people need to know that before coming to work here so they don't get disillusioned and understand that things take time"

The whole system needs to be funded, thinking about pathways not just hospital in isolation. There needs to be higher staffing levels with more time to work with patients, focusing on wellbeing and training and no cancellation of the training or groups. There still needs to be hospitals if the risks are too high, but this needs to be for the shortest time possible. People talked about the existing service they have got being increased in terms of having a pathway all within one service to make things more streamlined. A slow and steady discharge. The threshold should be higher in the community with being able to support people without having to use hospital. If social issues were addressed better then with early intervention within school and with CAMHS and social support people may not get to the point where they need hospital admission. In a crisis then people should be able to have a short inpatient admission and straight back into the community. People should not have to go out of area for support. There should be a program in place which teaches people about paying their bills; they should do this in hospital to prepare so they don't spend it on other things. There should be a follow up from the hospital and other people involved ensuring wellbeing on the road to recovery. Services need to be there when they are needed, at the moment people "up the ante" if they are not taken seriously and this is where people end up with index offences etc. There should be a 6/8 month limit for an inpatient admission. There is no recognition in CAMHS around PD which is not helpful as it means they don't intervene and early intervention is difficult leading to a big disconnect between child and adult services. There should be community based housing with a drop in hub – MDT, Recovery College, work opportunities, and a DBT package in the community.

"It needs to be more realistic – if they refuse to cook they don't eat"
"More normal – wish it didn't have to be like that"
"Hospitals are a safe haven into hell"
"Services should be there when they are needed. Have to be dying to be seen"

Recommendations from Staff Focus Groups

- There should be a higher community threshold with staff better equipped to support people in crisis without having to use hospital.

- There should be better early intervention through schools and CAMHS and them being more aware about emerging PD traits and how to support people better.

- If In a crisis then people should be able to have a short inpatient admission and straight back into the community.

- Access assessments should better identify when a service user is motivated to engage with the service model.

- Case managers and care coordinators should be more consistently involved throughout admission as well as community services to ensure a smooth transition, and FOLS teams where appropriate and discharge should be planned on or before admission.

- Whole pathways should be funded within an STP footprint to ensure no out of area placements where possible.

- Wards should be PD specific where possible and limited to 12 beds.

- Consider rebranding services as Trauma Focussed services

- There should be a specific model of care or approach that is based on formulation and that is well resourced and ensures consistency of approach from the MDT. This should include a strong supportive team with good leadership. The model of care should include formulation, DBT and schema therapy and consider the use of family therapy among other things

- A collaborative risk assessment that is dynamic and individual and allows for positive risk taking at the persons own pace should be developed as soon as possible into admission.

- Staff should be creative in order to promote and maximise service users involvement, motivation and engagement

- Staff should be mindful about the balance of reducing restrictive practice against risk management and the impact of these things.

- 1:1 observations should only be used when absolutely necessary and for the shortest time possible in order to maintain safety, however the benefits of not using these as a method of risk management should be carefully considered. 1:1 conversations should be used to manage a crisis situation in order to address what is happening for the service user.

- More practical support should be available around life skills, paying bills etc.

- Staffing levels should be high to ensure a focus on training and wellbeing and to ensure that activities and groups are not cancelled

- There should be a strong culture of support and regular supervision that includes both formal and informal approaches as well as internal and external sources.

- Recruitment strategies should involve recruiting staff who are passionate about working with this client group specifically, or that gives people an opportunity to get to know this client group in order to reduce any stigma or preconceptions around this. Consider the use of psychometrics.

- Induction training should be specific to Personality disorder and not just a generic induction to a ward or hospital. This should include information about self harm and should be open and transparent so as to adequately prepare people for this.

- There needs to be access to good training opportunities. This could include a baseline of awareness training, self-harm, resilience, PBS, Mental Health First Aid training, ASIST training and training around boundaries and supporting people with using DBT skills. KUF training should be available.

- There should be some choice around length of shifts i.e. long/short days to ensure staff don't burn out and are supported to maintain a good work/life balance.

- Staff should be trained to support service users to practice the skills learnt in therapies such as DBT. An insight into the different disciplines and what they deliver should be available to all staff so that they can support service users to consolidate the work they are doing.

- Service users should receive support to develop practical and transferable real life skills within the hospital environment or in the community to promote meaningful and structured opportunities for service users in the community.

- Once a service user is motivated to engage in therapy they should be stepped down into a community setting to complete this work, preventing lengthy admissions.

- After discharge there should be the opportunity for service users to stay connected to the ward for a time to ease the transition such as through the Recovery College. This would help to retain routine and structure. Consider a step down supported housing accommodation model where the same team can work with the service user through a hospital admission and out into the community, maintaining links and structure throughout the pathway. Appropriate, safe, stable housing should be identified in an area that is suitable for the service user. This could be community based housing with a drop in hub – MDT, Recovery College, work opportunities, and a psychologically informed care package in the community.

<u>Info from the PD Strategy Event at Sandal</u>

What has stood out?

Common themes –staff and patients. PD Specific. Need for training. Staff wanting to work on PD services. Consistent approaches across services. More "positives". Knowing people don't want to work with PD. Lack of link between community and inpatient. Females stay in services longer. Changing of observations (less 1:1). Lack of engagement in group sessions. Staffing ratio's. The theme of stigma. Safe banter and the value of this. Staff and service users' feedback was similar. The focus could be more positive. Staff updates training (lack of training for new staff). Step down services for PD's how to find them. PD'S self-harm more (misperceptions). Self-harming PT (moving staff out of their bedrooms does not help (collaborative approach to treatment). Boredom skills especially workshops. Recovery college needs relaunching (patient's motivation). Boundaries and least restrictive practice (balance) understanding of LRP.

Magic wand - recommendations

Smaller wards. More step down services. Link between services. Less agency knowing each other. Right /adequate staff support. Robust networking. Assessment +treatment. Community working. PD specific wards. Open to change. More time. Su's involvement. Robust recruitment. More activities. More education. More therapies (Family). More group work. Communication after discharge. Way of gradually decreasing observation levels – discharge. No mixed wards. Staff trained in PD. Staff motivating patients to engage in groups. Appropriate size ward and staff: patient ratio. Positive staff attitude. Staff training. Bigger grounds/facilities. Meaningful activity and staff to facilitate this. Same /similar model of care in different units.