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HAYLEIGH MILLAR

RECOVERY APPROACHES WITH WOMEN WITH A
DIAGNOSIS OF PERSONALITY DISORDER IN SECURE CARE

Section A: Literature review:

The application of recovery approaches to women with a
diagnosis of personality disorder in secure forensic care
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Section B: Empirical paper:

Exploring recovery with staff working with women with a
diagnosis of personality disorder in secure settings
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SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

DECLARATION FOR MAJOR RESEARCH PROJECT

Paper copy of declaration with Salomons, Canterbury Christchurch University

Acknowledgments

Firstly, I wish to express my gratitude to the participants of the study who shared their working experiences with me and thus made this project possible.

Secondly, I wish to acknowledge the support of both my supervisors, especially for their prompt and constructive feedback throughout the process. I am grateful for the support in accessing participants provided by my external supervisor and her manager, who also kindly reviewed the emergent model. I especially appreciated the practical and ‘anxiety-management’ support, particularly leading up to deadlines, provided by my internal supervisor and peers.

Lastly, I wish to thank my family and friends for their motivational support throughout this process. Most notably a big thank you to my partner for his unwavering support, patience, and hours of proof-reading.

Summary of the MRP portfolio

This portfolio is divided into four sections. It begins with a literature review in Section A which reviews the conceptual and empirical literature with regard to the usefulness and challenges inherent in applying recovery approaches in secure services, with a particular focus on women with a diagnosis of personality disorder.

Then Section B, an empirical paper, provides an account of a grounded theory study that entailed interviews with multi-disciplinary staff working with women with a diagnosis of personality disorder in a medium secure unit. The emergent theoretical model describing staff's understanding of, and means of applying, recovery approaches in this context is detailed and discussed in relation to the extant literature.

Section C provides a critical appraisal of the study as well as a personal reflection on what was learnt through the process of the conducting the study.

Finally, Section D provides supplementary information in the appendices, some of which is not necessarily referred to in the earlier text but is described in the contents list.

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Section A

The application of recovery approaches to women with a diagnosis of personality disorder in
secure forensic care

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Word Count:

5407 (plus 25 additional words)

Abstract

There is an increasing focus on recovery approaches in mental health services in the United Kingdom (UK). However, the appropriateness of recovery approaches for forensic mental health services has been questioned. This review examines conceptual and empirical literature regarding the complexities inherent in the use of recovery approaches for women with a diagnosis of Personality Disorder (PD) in secure care. Relevant approaches that incorporate recovery principles are discussed. Given the paucity of research in this specific area, studies that broadly explore recovery in secure units and/or forensic services are evaluated. The findings suggest that positive recovery outcomes can be achieved in forensic/secure services, both from staff and service-users' perspectives. However, a number of factors contradict the recovery ethos, including lack of individual choice in treatment, lack of freedom for risk-taking, and isolation from important relationships. The review highlights how services need to attend to the unique needs of women in secure care, which includes their gendered life experiences, often substantial trauma histories, preponderance of PD, and high co-morbidity rates. Further research involving service-users and staff across different levels of security is necessary to better inform forensic services' approach to care when recovery approaches are applied.

The Application of Recovery Approaches to Women with a Diagnosis of Personality Disorder in Secure Forensic Care

This review considers the applicability of recovery approaches with women with a diagnosis of Personality Disorder (PD) in secure care in the United Kingdom (UK). The review is divided into two parts. The first part aims to describe recovery models in the UK, the characteristics of women with a PD in secure care, and the identification of perceived difficulties associated with application of recovery approaches with this population group. The second part aims to examine the evidence for the utility of recovery models in these settings, concluding with identification of knowledge gaps and future research recommendations.

The literature for the review was sourced from searches of electronic databases, as well as manual searches of relevant reference lists and of the university library. Appendix 1 details the search strategy.

Recovery

‘Recovery’ is increasingly gaining prominence as a guiding principle for mental health services (Department of Health (DOH), 2001; 2006; 2007). The term recovery has different meanings to different people with two main divergent themes: Clinical recovery, aligned with the traditional medical model, focuses on symptom reduction; personal recovery, as developed from service-users’ perspectives, is more idiosyncratic with a focus on personal meaning in the process of recovery (Slade, 2009a). One of the first definitions of this concept states that “recovery involves the development of new meaning and purpose in one’s life, as one grows beyond the catastrophic effects of psychiatric disability” (Anthony, 1993, p. 11).

The recovery approach originated from the survivor movement, a social movement advocating social reform with an emphasis on self-help, which coincided with the reforms in

mental health services from institutionalised care to community provision. This was accompanied by a gradual shift in perspective regarding disability. Disability was no longer singularly seen as a result of illness/injury but rather, as Oliver (1983) argued, due to societal barriers, the stigma attached to illness/disability, and the resultant social distancing. As such, the recovery approach broadly incorporates the principles of social inclusion (Royal College of Psychiatrists, 2009) and a strengths perspective (Saleebey, 2006).

Recovery is considered to be a non-linear process with some people recovering from serious mental illness having described passing through a number of stages, in a cyclical spiral manner (Ralph, 2004). Andresen, Caputi, and Oades (2006), in their development of a measure of recovery, proposed five stages along the recovery journey:

- **Moratorium** – A time of withdrawal characterized by a profound sense of loss and hopelessness.
- **Awareness** – Realization that all is not lost and that a fulfilling life is possible.
- **Preparation** – Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills.
- **Rebuilding** – Actively working towards a positive identity, setting meaningful goals and taking control of one's life.
- **Growth** – Living a meaningful life, characterized by self-management of the illness, resilience and a positive sense of self.

However, applying such stage models may not be concordant with the service-user narrative of recovery as a uniquely personal journey of discovery (Repper, 2006).

Jacobson and Greenley (2001) put forward a recovery model in which recovery is seen to be positively influenced both by the individual's personal characteristics (internal conditions) and by environmental factors (external conditions). The internal conditions most notably include hope, the meaning given to healing, empowerment, and the capacity to

establish and maintain interpersonal relations. The external conditions include respect for human rights and recovery-oriented services, which entails equity in terms of power and resources. It is, however, unclear within this model how the interplay between these factors affects recovery.

There are, however, additional descriptions of the ‘recovery model’ in the literature which differ in perceptions of it as a process, a vision, and/or a set of values and principles (e.g. Deegan, 1988; Repper & Perkins, 2003; Roberts & Wolfson, 2004). These differences are not discussed here but are highlighted in two recent reviews of the recovery literature (Stickley & Wright, 2011a, 2011b).

In an attempt to develop an empirical conceptualisation of the recovery orientation, using data from a large systematic study of schizophrenia, Resnick, Fontana, Lehman, and Rosenbeck (2005) identified four domains of the recovery orientation: the capacity to feel empowered in one’s life; self-perceptions of knowledge about mental illness and available treatments; satisfaction with quality of life; and hope and optimism for the future. Slade (2009b) argued that personal identity and social context are vital in the recovery process, as aided through identity enhancing relationships, the development of self-management skills, and securing positive social roles.

Schon, Denhov, and Topor’s (2009) qualitative study highlighted some gender differences in the recovery process. Men tended to put greater value on such factors as medication, hospitalization and their own coping strategies, whereas women found therapeutic relationships, family support and organized activities outside the home, as conducive to their recovery. The authors suggested that more research was needed to explain this gender difference.

In the UK, the application of the recovery approach has included the introduction of service-user led Wellness Recovery Action Plans and the capabilities framework, which

emphasises how staff will use their skills to aim towards recovery (Copeland, 1999; Hope, 2004). The DOH (2001) explains that recovery-orientated services need to create an optimistic, positive approach to all people who use mental health services and support them in settings of their own choosing, enabling access to community resources: including education, work, friendships, or whatever service-users think is critical to their own recovery. Creating a positive, hopeful outlook assists an individual's sense of identity and increased meaning into the experience of mental health (Shiers, Rosen, & Shiers, 2009). However, tensions arise when recovery-oriented approaches collide with treatments focused on managing symptoms, a dependence on medications, an aversion to risk, and the neglect of psychosocial supports and the determinants of health (Stickley & Wright, 2011b). These tensions are prominent in forensic and secure mental health services, with some questioning the applicability of the recovery approach to these services (Pouncey & Lukens, 2010). It is also unclear whether the recovery research, which has centred on schizophrenia, is applicable to individuals diagnosed as having a PD. PD's are distinguished from mental illness by their enduring, potentially life-long nature and by the assumption that they represent extremes of normal variation, rather than a morbid process (Kendell, 2002). Staff within secure services have also been found to hold different views about their approach to care with service-users with a mental illness versus those with a PD label, with the latter seen as a management versus a clinical issue (Mason, Caulfield, Hall, & Melling, 2010).

Women in Secure Care

Women form a minority in secure psychiatric care, which was principally developed to meet the needs of men. In a review of the literature on women in secure care, Lart, Payne, Beaumont, Macdonald, and Mistry (1999) highlighted that women in secure care are more likely to have a diagnosis of PD, in particular borderline PD, than men, with a high degree of substance abuse, self-harming behaviour, and co-morbidity. Hemingway (1996) found that

women made up less than one fifth of the population in secure settings in Britain, presenting as a heterogeneous group with a wide range of ages, personal, psychiatric, and forensic histories (Dolan & Bland, 1996). Stafford's (1999) report described how women's pathways to high-security care tended to include childhood abuse, disrupted care and education, little experience of paid employment, self-damaging behaviour, numerous psychiatric admissions, and assaults on staff or damage to property. Women are seen to move up through levels of security due to the difficulties staff encounter in containing them in other psychiatric settings (Scott & Williams, 2004), whereas men were more likely to have committed a serious violent or sexual offence and were detained due to risks they posed to society. Therefore, it has been recommended that treatment regimes specific to the needs of women in secure care are required (Coid, Kahtan, Gault, & Jarman, 2000). These regimes would need to take account of women's substantial trauma histories, problems with substance dependence, self-harm behaviour, and personality pathology (Lewis, 2006), incorporating their role as parents, as a majority of women in prison were found to have children (Rutherford & Taylor, 2004). This is similar to recommendations from research into women's recovery needs, which recommends a strength-based philosophy that allows for therapeutic risk-taking, especially with self-harming behaviour (Copperman & Hill, 2006).

Even though not all service-users in secure care have committed an offence, but rather admitted because of assessed dangerousness or risk to self, their care falls within the remit of forensic services. As such, these services-users need to contend with the recovery implications of a double stigmatisation of both mental illness and offender labels. Forensic service-users can be detained for long periods and the high demand of existing resources can limit movement within the psychiatric services (Murray, 1996). Furthermore, many women are placed out-of-area, further from their social networks (Williams, Scott, & Bressington,

2004). These combined factors could constrain the operationalization of the recovery principles of hope, optimism, independence, and autonomy.

Despite evidence suggesting that staff in secure services are aware that abuses of power, social disadvantage, and gendered experience, significantly shape women's mental health difficulties/needs (Williams & Waterhouse, 2000), this does not appear to be shaping appropriate practice (Stafford, 2000). This may be due to the highlighted lack of women-only research, treatment model or regimes (Lart et al., 1999). Additionally, research concerning mental health and inequalities is often based on community samples and is rarely service specific (Williams, Scott, & Waterhouse, 2001), limiting its applicability to those women in secure settings. Hence, it is likely that staff supporting recovery with this unique group of service-users may themselves face multiple challenges.

Staff Challenges in Applying a Recovery Approach

Anthony (1993) points out that recovery can occur without professional intervention. Professionals can enhance or hinder the recovery process depending on their approach to care and provision of a facilitating environment (Onken, Craig, Ridgway, Ralph, & Cook, 2007). Within secure services, the service-user's main contact is with the professional network, and therefore staff play a greater part in identity formation and meaning making during the recovery process.

Staff work within an evidence-based climate where outcomes are related to reduced re-offending and re-admission, and symptom reduction. These outcomes are not necessarily compatible with recovery needs of hope, empowerment, spirituality, and subjective experience (Meehan, King, Beavis, & Robinson, 2008). Furthermore, outcome assessment is itself complicated when the diagnostic assessment for the presence of PD entails review of, at least, the previous five years of a service-user's life (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) and the reliability of diagnosing PD is questioned (Pilkonis et al., 1995).

The adoption of a recovery approach in secure services for women with PD would need to include cognisance of the broader literature regarding this client group. Theoretical literature has described how work with such patients impacts on staff at both an individual and organisational level (Kurtz, 2005; Menzies-Lyth, 1960; Winnicott, 1949). In a literature review exploring the difficulties encountered in forensic psychiatric nursing, Mason (2002) categorised five major issues: negative and positive views; security versus therapy; management of violence; therapeutic efficacy; training and cultural formation. These provide an insight into some of the complexities in applying a recovery model to work with women with PD in secure settings.

From the outset, service-users are invariably detained in a place not chosen by themselves, which inevitably compromises their capacity to exert control over their treatment. The service itself may be more focused on change and risk reduction rather than acceptance and pursuing of service-users' defined goals (Turton et al., 2009). Parry-Crooke and Stafford's (2009) report on consultation with women in secure services highlighted that many service-users reported not being involved in the development or review of their care plan. Those that were aware of their care plans reported them as relating to single problems rather than a set of aims with a specific method on how to achieve them. In a study by Corrigan et al. (2005), service-users reported they wanted assistance with family relationships, other interpersonal relationships, cognitive and emotional psychiatric symptoms, activities of daily living, achieving major life goals, general health problems, and employment. It is thus immediately evident how this poses a challenge to staff promoting recovery in secure care, where service-users are excluded from society and, in turn, their valued interpersonal relationships, activities are limited by the resource constraints of a secure facility, and employment is not necessarily feasible.

The recovery literature focuses on the process of engendering hope and the possibility of change at some meaningful level (Anthony, 1993). Yet individuals who receive the diagnosis of PD experience limited access to services, cycles of rejection from mental health services, and an ensuing dilution of hope (Haigh, 2007; Horn, Johnstone, & Brooke, 2007). The diagnosis has been associated with a range of negative attitudes among mental health service staff (Brody & Farber, 1996; Fraser & Gallop, 1993; Gallop, Lancee, & Garfinkel, 1989; Lewis & Appleby, 1988; Markham & Trower, 2003), with pessimistic views on efficacy and treatment outcome in secure services (Bowers, McFarlane, Kiyimba, Clark, & Alexander, 2000). These views can be detrimental to the well-being of both service-users and staff (Deans & Meocevic, 2006), especially as the attitude of services and their staff have been marked as crucial in the promotion of recovery (Buchanan-Barker & Barker, 2008). However, a more recent qualitative study (Fortune et al., 2010) on male service-user and staff' views about three newly established medium-secure services for people with a diagnosis of PD, highlight how both were noticing positive changes in service-users' self-esteem, reduction in self-harm, improved communication and insight into their behaviour. Many service-users expressed that treatment had given them a sense of purpose in life and hope.

Fortune et al. (2010) reported that most staff working in these services had found the work exhausting, draining, and sometimes frightening. Storey and Murdock (2001) maintain that emotional, verbal, and physical attacks on caregivers are commonplace when working with women in secure care, with staff sickness higher than other mental health services. Women's wards are known for their emotionally intense atmospheres (Williams, Scott, & Waterhouse, 2001) and repeated acts of violence and self-harm, which can challenge clinicians' desire to help and support (Jeffcote & Travers, 2004; Wilstrand, Lindgren, & Olofsson, 2007). In a qualitative study of staff and service-users' views on violence, Janicki

(2009) highlights how victimisation from violence, directly or through witnessing, can impede recovery in medium-secure units. However, Bowers' (2002) research with nurses working in high-secure hospitals, suggested that some professionals do manage to sustain a positive approach to individuals with PD. This coincided with their belief in the uniqueness of the individual and their problems; commitment to values such as honesty, equality, and individual value; cognitive and emotional self-management; mastery of interpersonal skills; teamwork skill; and organisational support. These factors would be consistent with the recovery approach and could possibly facilitate its application.

The first step in promoting recovery-orientated care is the establishment of a collaborative relationship (Caldwell, Sclafani, Swarbick, & Piren, 2010) which is consistent with the notion of relational security, encouraged in secure settings (DOH, 2002; 2010). Research exploring recovery and relationships, and clinical opinion of working therapeutically with women in secure units, indicate that strong clinician-patient relationships with relational continuity and a caring, collaborative approach are found to facilitate recovery and an improved quality of life (Green et al., 2008; Lambert & Turcan, 2004). However, this is complicated in the treatment of PD where pathological interpersonal relationships are a key diagnostic feature, and more so, in secure units with frontline staff responsible for balancing security, the anxieties and expectations of society and risk-averse services, the political jurisdiction and the Ministry of Justice's directives, and therapeutic aspects of care (Adshead, 1998; Mezey & Eastman, 2009).

Women in secure mental health services present with complex care-seeking behaviours that can undermine helpful therapeutic alliances, necessary for recovery promotion (McMillan & Aiyegbusi, 2009). Aiyegbusi (2004) described how women on a locked ward adopted roles of victim and/or perpetrator, resulting in bullying and exploitation. The high degree of self-harming among these women further affects staff responses to care,

as they feel overburdened by feelings of fear, frustration, and helplessness (Wilstrand, Lindgren, & Olofsson, 2007). Staff working with this group are said to experience strong emotional reactions (Main, 1957) that have been partly explained in terms of transference and counter-transference, as service-users communicate their past and current experiences in often unconscious ways (Kurtz, 2002). In a review of a medium-secure PD service, Clarke and Ndegwa (2006) reported how staff can often find it difficult to control their counter-transference reactions. This can result in damaging re-enactments between staff and service-users of past abuse (Wilkins & Warner, 2000). Staff are also said to withdraw emotionally from service-users and their experiences, to defend against negative emotions (Hinshelwood, 1999; Rae, 1993). Therefore, the likelihood of establishing empathic and supportive therapeutic relationships may be reduced.

Research has indicated that to maintain a high positive attitude among staff, units need a clear, consistent philosophy and treatment regime (Bowers et al., 2005). It has been proposed that an emphasis on recovery offers an inclusive, humanistic philosophy that gives direction and ambition to professionals and service-users. This shared understanding is essential as it is common to find inconsistency in approaches amongst multi-disciplinary teams (MDT) working with individuals with PD, and 'splitting' is found to be widespread in secure services for women (Bateman & Tryer, 2004; Grounds et al., 2004; McMillan & Aiyegbusi, 2009). This splitting may be a representation of a service-user's inner processes arising in the context of staff's own unresolved transferences or emanating from the service-users' projections (Bateman & Tryer, 2004). However, splitting may also be caused by poor team communication, partly due to MDT staff's differing perspectives on treatment (Carr-Walker, Bowers, Callaghan, Nijman, & Paton, 2004). These differences could be evident with the application of a recovery approach, as MDT staff have been found to hold different views on recovery (Pouncey & Lukens, 2010; Summers, 2003).

Gillespie and Flowers' (2009) qualitative study of forensic nurses' experiences suggested that a transition is taking place in mental health nursing, with participants expressing a desire to embrace an ideological shift, from more custodial practices and cultures, towards a rights-based and a recovery approach to care. What this recovery approach to care might entail with women with PD in secure settings, and how relevant stakeholders perceive it to be, requires further clarification.

Recovery Models Specific to Women with a Diagnosis of PD in Secure Care

The theoretical literature refers to some approaches or models that include, or support recovery principles, while incorporating some of the wider complexities inherent in work with women with a diagnosis of PD in secure settings.

It has been suggested that understanding the complex care-seeking behaviour displayed by women with PD in secure services, in light of attachment theory, may help manage this behaviour and provide a 'secure base' for service-users moving towards recovery (Adshead, 1998). Individuals with a diagnosis of PD who are considered a risk to others have usually experienced inconsistent, neglectful or abusive behaviour from primary attachment figures (Kurtz, 2002). According to attachment theory (Bowlby, 1969), these experiences are internalised as a 'working model' of important relationships for the individual and, as such, they are likely to rely on models of frustrating, unavailable or abusive carers. Mental health practitioners, especially in-patient staff, will often trigger associations with primary attachment figures and become emotionally significant to patients in their own right (Adshead, 1998). In forensic services, this is enhanced by the control vested in staff, evoking memories of authoritarian and depriving childhood relationships. It is thus through the establishment of a secure base that recovery can be actualised for both staff and service-users (Aiyegbusi, 2009). Factors which contribute to this sense of emotional safety include: the creation and maintenance of boundaries between staff and patients to protect therapeutic

space; the careful management of separation, loss, and the avoidance of abrupt endings; and the monitoring, naming and regulating of affect in staff and patients to promote the capacity of patients to understand themselves in relation to other people (Kurtz, 2002). The feasibility of this approach in an all-female medium-secure hospital has been clearly described by Barber et al. (2006), though its effectiveness is yet to be evaluated.

The identification of means to work with the inherent tensions between risk management and the promotion of recovery principles had long been grappled with within the therapeutic community literature. Haigh (1999), building on the original themes of therapeutic communities (Rapoport, 1960), highlights five key conditions of a therapeutic culture that facilitates empowerment through human relations:

- Attachment: A culture of belonging;
- Containment: A culture of safety;
- Communication: A culture of openness;
- Involvement: A culture of participation and citizenship;
- Agency: A culture of empowerment.

Though therapeutic communities have been phased out of the National Health Service, the underlying principles may arguably be applicable to this client group, especially in secure settings (Byrt, 1999).

Ward's (2002) strength-based model, labelled the 'good lives model' (GLM), was developed to provide a framework and means to enhance therapeutic effectiveness in forensic settings, where low motivation to change and low compliance with treatment are considered major problems (Gudjonsson & Young, 2007). GLM focuses on equipping patients with the skills required to achieve goals, where the primary aim is improved adaptive functioning and quality of life, rather than focusing exclusively on managing risk. The GLM is considered to fit well within the principles of the recovery model as it focuses on building hope and

working collaboratively with service-users to build on their strengths (Repper & Perkins, 2003). However, its specific applicability to women with PD in secure care has not been reported on.

Another recovery model that has been applied to forensic settings, in New Zealand and the UK, has been the Tidal model (Barker, 2001). The model was developed from an extensive five-year study of ‘the need for nursing’ with its philosophical underpinnings drawing upon the work of interpersonal relations theorists and theories of empowerment in interpersonal and educational contexts (Barker, 2000). It is a model based on helping people to share their stories, and understand what mental health means for them. The model incorporates an empowering person-centred approach to recovery, guiding nurses’ practice to facilitate a high level of engagement with patients and it is said to provide a means to instil hope in a systematic manner (Hillbrand & Young, 2008). However, the model’s effectiveness in establishing its aims is yet to be established.

Relevant Empirical Studies

A systematic search did not reveal any studies specifically related to recovery for women with a diagnosis of PD in secure forensic services. As such, the few studies that relate more broadly to forensic services, not specifically female or PD, were included for review.

Turton et al.’s (2009) qualitative study compared the narratives of recovery amongst six male and female users of three specialist mental health services – eating disorder, dual diagnosis, and forensic. They found that forensic participants highlighted factors that hindered recovery such as the physical environment (the lack of space and access to outdoors), as well as the potential losses that recovery may entail, such as the loss of safety offered by the locked ward/unit. Themes corresponding to the more conventional ‘clinical’ model of recovery particularly emerged in the dual diagnosis and forensic participants.

These participants expressed a desire to be 'symptom free' while acknowledging the need for professional input and medical intervention to support this. A common theme concerned the struggle inherent in recovery, with participants describing the difficulties in managing the physical and emotional pain of treatment (e.g., unwanted side effects), and the feelings of helplessness.

An extension of this study was conducted by Mezey, Kavuma, Turton, Demetriou, and Wright (2010). The number of forensic patients with a diagnosis of schizophrenia or schizo-affective disorder interviewed was increased to ten (eight men and two women) with the purpose of exploring themes specific to this group. Most participants defined recovery as getting rid of symptoms and feeling better about themselves. Medication and psychological work, relationships with staff, and being in a secure setting were cited as being important in bringing about recovery. Many participants described how the unit had provided them with a sense of acceptance, inclusion, and companionship that they had not previously encountered. The amount of time spent in the units was helpful in their recovery, allowing reflection and forgetting. The stigma associated with being an offender, as well as having a serious mental illness, was perceived as factors holding back recovery, particularly in relation to discharge and community living. Some participants viewed the unit as not only protecting the public from them but also rather protecting them from a hostile external environment, where their recovery was contingent on the forgiveness and acceptance of the outside world. This fear is founded in survey evidence of the public's high levels of fear and intolerance towards people with mental illness (Brooker & Ullman, 2008). The core recovery concepts of hope, self-acceptance, and autonomy were more problematic and less meaningful to participants detained for serious and violent offences, which may not necessarily apply to women in secure care whose offences, or lack of offences, may differ to men.

In an evaluation of the implementation of the recovery philosophy in a medium-secure service in the UK, Corlett and Miles (2010) measured MDT staff and male service-users views on recovery using the Developing Recovery Enhancing Environments Measure (DREEM: Ridgeway & Press, 2004). Staff and service-users agreed that three of the 24 DREEM recovery elements (meaning, hope, and positive relationships) were very important, rating them in their top five. Staff and service-users rated all elements of recovery as at least moderately important (above median value). However, staff consistently rated all 24 elements as more important than the service-users, and rated the elements of recovery as better implemented, except intimacy and sexuality. There was a significant effect of service-users' forensic history (restriction status and index offence type) on ratings of how well elements of recovery were implemented, which may not necessarily apply to women with a diagnosis of PD in this setting. Challenging stigma was one of the highest rated elements of recovery being implemented, suggesting that it is a key issue for forensic services. In comparison, Dinniss, Roberts, Hubbard, and Hounsell (2007) found that Control and Empowerment and Personal Identity were the highest implemented recovery elements in a community sample, which may reflect the difficulties of implementing them in a forensic setting.

In a phenomenological study of the Tidal Model as experienced by male and female service-users and nurses in a forensic unit in New Zealand, Cook, Phillips, and Sadler (2005) demonstrated that participants found the model enhanced participation and collaboration within therapeutic relationships. The unit's shift in culture, following implementation of the model, was said to engender feelings of hope and optimism in both staff and service-users. The levelling/shift in power was seen to enhance service-users' sense of self and connectedness in relationships, with these changes being noted by service-users as positive for their recovery. Thus, the authors argued that the model enabled an interpersonal process

wherein nurses were professionally satisfied and service-users were validated in their experiences, supporting their recovery. Though this study would indicate that some positive recovery outcomes, linked to identity, relationships, hope and optimism, can be obtained in forensic services, it does not include reference to the other recovery domains of empowerment, satisfaction with quality of life, meaning and purpose. While the emphasis on relationships may be beneficial to women, as indicated in broader recovery research, it remains unclear if this model would be helpful with those with a PD diagnosis.

Barsky and West (2007) explored the scope for recovery in a medium-secure hospital ward in comparison to a high-secure ward from which the service-user participants were transferred. All male participants had a history of serious and violent offending, were detained under the Mental Health Act, and were diagnosed with either a psychotic illness or personality disorder. The recovery themes of hope, empowerment, connection, human rights, and a recovery-orientated culture of healing were central in service-users' responses. Participants identified an increased scope for recovery at the medium-secure facility, which was promoted by the decreased emphasis on security. Factors identified as promoting recovery included the increased access to a range of activities, graded access into the community, the more stable and less tense or violent atmosphere, and the increased potential for developing trusting relationships with helpful, friendlier staff and peers. The use of psychological therapies was seen as beneficial for recovery, however, access to therapy was perceived as better in the high-secure setting. The highlighted differences between the two settings indicate how medium-secure settings may be more conducive to recovery approaches aided by decreases in security. However, the differences in atmosphere and opportunity to build relationships raises the question as to whether the previously mentioned challenges in working with this service-user group are more pronounced within high-secure units,

impacting the establishment of therapeutic relationships and the promotion of recovery. This indicates the possible need for different recovery models for different levels of security.

Gudjonsson, Webster, and Green (2010) investigated the attitudes of 137 MDT staff towards the recovery approach in forensic mental health services and the impact of training on staff knowledge and attitudes, using a specially constructed 50-item recovery approach questionnaire. The findings demonstrated that the majority of both those that had received training (96%), and those without (84%), were positive about the implementation of the recovery approach. Staff training had a significant impact on a number of items, including staff reporting greater familiarity with the principles of the recovery model, believing that recovery does not mean that the service-user becomes symptom-free or that treatment has to commence before the recovery approach can be applied. After training, almost all staff believed (from 72% to 93%) that the recovery approach would work with patients compulsorily detained in hospital, although greater uncertainties were reported concerning service-users with PD (from 56% to 79%). This study included an overview of forensic services with no gender difference recorded, however, it does highlight that though the implementation of the recovery approach to forensic services is positively perceived, this may not be as clear in regards to PD. The significant changes after training does indicate the need for recovery training for staff working in forensic services.

Conclusion

Recovery has become popular in mental health discourse and currently underpins policy and service delivery initiatives. There is increasing pressure on service-providers to ensure that the services offered to people with mental illness are recovery-oriented, and this now includes forensic services and services for people diagnosed with a PD. Women with a diagnosis of PD in secure settings form a small minority of service-users in a system principally designed to meet the needs of men, who often have different needs based on their

offending, mental health, and gendered histories. The complexities in working with this group of individuals are well reported, yet research into what may promote recovery with this group is limited (Long, Fulton, & Hollin, 2008). This review highlights that application of the recovery model would need to consider the needs of the particular population, as its relevance may have little meaning in this group of service-users (Mezey et al., 2010). As such, the recovery approach may need to be modified for use in forensic psychiatric services and potentially across different levels of security. Despite the number of raised potential challenges to application of the recovery approach in these settings there does appear to be emerging evidence of positive recovery outcomes that can be achieved from both staff and service-user perspectives. However, the scarcity of research into the meaning of recovery or application of recovery approaches in forensic services, with the lack of any women-only or PD-related studies, is noteworthy given the government's incentives promoting its implementation. Staff and service-users are thus operating within recovery-orientated services that have yet to be found directly meaningful and supportive for this specific group.

Recommendations

The scarcity of directly relevant research highlights how any future recommendations need to include a call for research into recovery in forensic services. Furthermore, research exploring recovery within subsets of this group such as women, and women with a diagnosis of PD is required. This research could entail qualitative approaches exploring both staff and service-users' perspectives on recovery, as well as evaluation of recovery measures and of some of the recovery-based approaches that have been developed for forensic services. This research could inform services' approach to care but also the training, support, and resource needs of services and staff.

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Section B

Exploring 'recovery' with staff working with women with a diagnosis of personality disorder

in secure settings

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Abstract

Background. Some studies have suggested that recovery approaches could be facilitated in secure mental health services despite a number of inherent tensions. However, none have explored if this applies to women with a diagnosis of personality disorder in secure care. A group whose needs have historically been overlooked, and can present with complex care-seeking behaviours.

Aims. To explore how staff working with these women understand and apply recovery approaches in secure units.

Method. Eleven multidisciplinary staff members working in a medium-secure unit in the UK participated in in-depth interviews. The data were analysed using grounded theory.

Results. A preliminary model was generated, which comprised of five categories: secure base, balancing tensions, therapeutic relationship, initiating recovery, and nurturing recovery. These appeared to interact and influence each other throughout the recovery process.

Conclusions. Staff are required to continually balance a number of tensions and as such they need a secure base from which to explore the service-users' unique recovery process through the medium of collaborative therapeutic relationships. Staff sharing a recovery ethos that is embedded in the culture of a conducive environment, and is supported by supervision and teamwork, fosters the actualisation of recovery principles of empowerment, identity formation, and hope.

Declaration of interest. None.

Exploring Recovery with Staff Working with Women with a Diagnosis of Personality Disorder in Secure Settings

‘Recovery’ is increasingly gaining prominence as a guiding principle for mental health services, including forensic services (Department of Health (DOH), 2001; 2006; 2007). There are, however, a number of descriptions of the ‘recovery model’ differing in perceptions of it as a process, a vision, or a set of values (Stickley & Wright, 2011a). Additionally, Schon, Denhov, and Topor (2009) have pointed to some gender differences during the recovery process; men tended to prioritise medication, hospitalization, and personal coping strategies; whereas women found therapeutic relationships, family support, and activities outside the home conducive. Copperman and Hill (2006) highlight how recovery approaches should attend to the unique mental health needs of women, which includes cognisance of the social inequalities women have endured in mental health services. This is possibly paramount in secure services where women form a minority in a system principally designed for men (Hemingway, 1996).

The DOH (2001) encourages recovery-orientated services to create an optimistic, positive approach to mental health service-users and support them in settings of their own choosing, enabling access to community resources. However, tensions arise when recovery-oriented approaches collide with treatments focused on managing symptoms, medication dependence, aversion to risk, and neglect of psychosocial supports; prominent in forensic and secure mental health services (Stickley & Wright, 2011b). This is exemplified by Parry-Crooke and Stafford’s (2009) findings that many women in secure services reported not being involved in the development, or review, of their care plans. Furthermore, Mason’s (2002) literature review identified tensions encountered in forensic psychiatric nursing that included: staff’s negative and positive views; security versus therapy; management of violence; therapeutic efficacy; training and cultural formation. Although these tensions

between risk management and promotion of recovery principles have long been grappled within therapeutic community literature (Haigh, 1999), a query regarding the applicability of the recovery approach to these services remains (Pouncey & Lukens, 2010).

These difficulties in application in women's forensic services are compounded by the highlighted lack of women-only research, treatment models, or regimes (Lart, Payne, Beaumont, Macdonald, & Mistry, 1999). Women, compared to men, in secure care tend to have higher rates of personality disorder (PD; Lart et al., 1999), have less serious, violent, or sexual offences, and move up through levels of security due to staff difficulties in managing them in other settings (Scott & Williams, 2004). Therefore, it has been recommended that treatment regimes take account of women's substantial trauma histories, problems with substance dependence, self-harm behaviour, and personality pathology (Coid, Kahtan, Gault, & Jarman, 2000; Lewis, 2006).

It is unclear whether the recovery research, which has primarily centred on schizophrenia, is applicable to PD, which is distinguished from mental illness by its enduring, potentially lifelong nature and the assumption that it represents extremes of normal variation (Kendell, 2002). Recovery approaches focus on engendering hope and change at some meaningful level (Anthony, 1993). Yet literature suggests individuals with PD experience limited service access (Haigh, 2007; Horn, Johnstone, & Brooke, 2007); encounter a range of negative attitudes among mental health professionals (Lewis & Appleby, 1988; Markham & Trower, 2003); with pessimistic views on treatment efficacy in secure services (Bowers, McFarlane, Kiyimba, Clark, & Alexander, 2000). Furthermore, women in secure services present with complex care-seeking behaviours that can undermine therapeutic alliances (McMillan & Aiyegbusi, 2009) and the high degree of self-harming affects staff responses to care, as they feel overburdened by feelings of fear and helplessness (Wilstrand, Lindgren, & Olofsson, 2007). However, there is some evidence to suggest that forensic staff have positive

attitudes regarding the recovery approach with detained patients (Gudjonsson, Webster, & Green, 2010) and that some nurses in high-secure hospitals can sustain positive approaches to individuals with PD (Bowers, 2002).

Within secure services, the service-user's main contact is with the professional network, and staff therefore play a large role in identity formation and meaning making during the recovery process (Onken, Craig, Ridgway, Ralph, & Cook, 2007). Research has shown that strong clinician-patient relationships with relational continuity and a caring, collaborative approach can facilitate recovery for women in secure units (Green et al., 2008; Lambert & Turcan, 2004). However, this is complicated in the treatment of PD where pathological interpersonal relationships are a key diagnostic feature, and more so, in secure units where staff are balancing security and therapeutic aspects of care (Adshead, 1998; Mezey & Eastman, 2009), alongside different multidisciplinary views on recovery (Summers, 2003).

It has been suggested that an attachment framework provides a means to understand and work with the complex care-seeking behaviour displayed by women with PD in secure services (Adshead, 1998; Aiyegbusi, 2009). This requires attention to a range of factors to promote a sense of emotional safety for service-users (Kurtz, 2002). Barber et al. (2006) have described the feasibility of this approach in an all-female medium-secure hospital, though its effectiveness is yet to be evaluated. These general principles do, however, extend to a number of psychological PD treatments (see Bateman & Tyrer, 2004a, for discussion).

Furthermore, Ward's (2002) good lives model and the tidal model (Barker, 2001) are considered applicable to forensic settings and are deemed to fit well within recovery principles (Hillbrand & Young, 2008; Repper & Perkins, 2003). A study of staff and service-users' views indicated that the implementation of the tidal model could have positive recovery outcomes in secure services (Cook, Phillips, & Sadler, 2005), especially for women,

due to the emphasis on relationships. However, neither model's effectiveness with women with PD in secure care has been reported on.

The empirical literature regarding recovery in secure services would appear to be limited. Research exploring recovery with male and female forensic service-users identified that the lack of space and outdoor access, and the losses that recovery may entail (e.g., loss of safety and acceptance by ward/unit) hindered recovery (Turton et al., 2009). Factors important in bringing about recovery were medication, therapy, and relationships with staff. Recovery concepts of hope, self-acceptance, and autonomy were less meaningful to those detained for serious offences (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010), which may not necessarily apply to women in secure care. Barsky and West's (2007) study with male forensic service-users highlighted an increased scope for recovery in a medium-secure facility, possibly due to decreased emphasis on security, compared to high-secure wards. However, access to therapies, seen as beneficial, was perceived as better in the high-secure setting. Despite the government's incentives to promote recovery in forensic services the scarcity of research into understanding and applying recovery approaches in these settings, particularly with staff working with women with a diagnosis of PD, limits services' ability to shape appropriate practice. The experiences and needs of these women, as well as the effects of different service models, have been identified as key gaps in the research (Lart et al., 1999). Given the requirements for gender sensitive services (DOH, 2003) and the recent legislative/policy changes that impact upon the care of individuals diagnosed with PD (National Institute for Clinical Excellence (NICE), 2009a; 2009b), it is necessary to raise awareness of these individual's needs (Webb & Macmurrin, 2007).

The aim of this study was to develop an explanatory model for staff working in secure units for women diagnosed with PD, to answer the following questions:

- How do staff understand recovery?

- Do staff think the concept of recovery is useful, relevant, and applicable to their work?
- What is their experience of providing a recovery-oriented service?
- What facilitates the application of recovery principles?
- How do staff conceptualise their role in relation to recovery?

Method

Design

A qualitative design was employed due to the exploratory nature of the research questions. Qualitative research offers a means to capture the complexity (Smith, 2003) and interplay of factors that were assumed involved in applying a recovery approach. As this was an under-theorised area, grounded theory offered a systematic approach to construct a comprehensive understanding of this social phenomenon grounded in the data (Charmaz, 2006). A social constructionist interpretation of grounded theory (Charmaz, 2006) was adopted for this study. As such there is an assertion that there is no absolute truth but rather different interpretations of reality formed in language (Walker, 2006), in this case, shaped through the social constructions of recovery, personality disorder, offender, and women. Charmaz (2006) contends that through the research process reality is co-constructed by the researcher and participant and is therefore partly shaped by the researcher. For this study, the researcher's experience of working with individuals with a diagnosis of PD and offenders in community settings was relevant.

Ethical Considerations

Ethical approval was granted by the local NHS Research Ethics Committee and the participating trust's Research and Development Committee (Appendix 3). The study was conducted in accordance with the Health Professions Council (2008) and the British Psychological Society's (2006) codes of conduct. The aim of the study had been to explore

staff's experiences of utilizing a recovery approach with service-users in general and, therefore, staff were not directly asked about, or encouraged to discuss, specific cases. Consequently, no specific service-user's details or service-users' names were provided in any of the interviews.

Participants

A six-bedded women's medium secure unit was approached to participate in the study. The unit employed a recovery philosophy in work with the female offenders, the majority of whom had been diagnosed with PD. All 17 permanent staff members, plus any current students on placement or bank staff, were invited to participate. Eleven multidisciplinary staff members, the majority (nine) of which were permanent staff members, participated in the study.

Procedure

Participants were informed about the study via a poster advertising the study (Appendix 4). The author also presented the study at a multidisciplinary team meeting on the unit. Potential participants were given an information leaflet (Appendix 5). An interview time was arranged with those that volunteered to take part. At interview, participants' written consent was obtained (Appendix 6) and participants completed a brief demographic form (Appendix 7). Interviews lasted between 45 and 75 minutes and took place in an appropriate room on the unit. Participants were informed that they could leave the interview at any time should something on the unit demand that, or they wanted to stop. A semi-structured interview schedule was developed (Appendix 8), following a review of literature, and was piloted with a colleague not related to the study. The schedule guided interviews with broad open questions to allow participants to produce their own understanding. Some questions entailed prompts for clarification or guiding the focus of the interview. As the study progressed, these prompts were adapted in order to explore emerging themes. All interviews

were digitally recorded and transcribed verbatim with identifying information removed. Selected interviews were transcribed by a professional who signed a confidentiality disclaimer (Appendix 9).

Data Analysis

Interview transcripts were analysed using grounded theory procedures (Charmaz, 2006), with some techniques from Strauss and Corbin (1990) adopted to aid the analytic process. Data collected from five interviews were open coded using line-by-line coding and the most frequently occurring codes were used in focused coding of the remaining interviews. These codes were expanded and adapted to accommodate the different experiences of participants. Axial coding was used to relate conceptually similar codes together. Constant comparative analysis (Glaser, 1978) was continually used to compare codes across and within transcripts as new data emerged. Theoretical coding was used to relate substantive codes to each other and develop the emerging theory. Memo-writing and clustering (a form of diagramming) were used throughout to develop tentative categories and initial hypotheses, and ensure that codes and categories were grounded in the data. No new themes appeared to emerge after interview ten.

Quality Assurance

To establish trustworthiness in the data the three major categories, as described by Williams and Morrow (2009), were attended to. Throughout the study, a research diary (Appendix 10), which included analytic memos, was written to maintain an audit trail of the study and the analysis; and to record assumptions and biases. Peer grounded theory researchers were regularly consulted regarding methodology, coding, and the emerging model. In the case of disparities in coding, discussions were held until agreement was reached and amendments made accordingly. Supervision was used to check on the emergent analytic account, to monitor for clarity and the degree to which the categories were evident in

the data. A summary of the results was sent to all participants for respondent validation (Mays & Pope, 2000). Furthermore, the results include direct quotes to ground the theory in the data.

Results

Participant Information

Table 1 provides an overview of the participants' professional backgrounds, years of service, and training history.

Variable	Answer	Number of Participants
Profession	Nursing ^a	7
	Allied health professionals ^b	4
Length of time in profession	0-5 years	4
	5-10 years	3
	10+ years	4
Length of time on this unit	0-5 years	9
	5-10 years	1
	10+ years	1
Previous work in secure units	Yes	4
	No	7
Previous work - sex of wards	Male	2
	Mixed	2
Previous work - years spent	0-5 years	2
	10+ years	2
Length of time working with PD	0-5 years	8
	5-10 years	1
	10+ years	2
Length of time working with offenders prior to this unit	0-5 years	10
	10+ years	1
Any training on PD	Yes	9
	No	2
Was PD training specific to women	Yes	4
	No	7
Any training on recovery	Yes	7
	No	4

Note: ^aIncluding support workers. ^bIncluding occupational therapy; psychology.

Model Summary

In the initial coding stage, 127 codes were generated. These were condensed to 60 axial codes that subsequently led to 18 theoretical codes. Five main categories emerged from the data, with 16 iteratively generated subcategories, which appeared to interact and influence each other, which suggested a movement across categories.

The results demonstrated in figure 1 illustrate that as staff members encounter a number of tensions through the recovery process they would intermittently return to re-establishing their secure base and/or the therapeutic relationship. The results suggest that staff are continually required to balance a number of tensions and as such staff need a secure base from which to explore the service-user's unique recovery process through the medium of the therapeutic relationship.

The category of 'balancing tensions' captured the range of inherent service and societal challenges that staff are required to negotiate when implementing the recovery model in secure services. These challenges are perhaps more pronounced in this setting, than in community settings, where the immediate environment and the service directives regarding risk reduction present a number of constraints on the implementation of recovery principles. These tensions are repeatedly encountered throughout the recovery process, and thus promoting recovery in this context requires the ability to continually revisit and renegotiate a range of internal and external stressors.

The challenges within 'balancing tensions' appeared to be compounded by working with woman, in comparison to working with men, in secure units. Some participants described how the women's difficulties could at times resonate more with them and that staff's perception of vulnerability in the women enabled them to emotionally connect or empathise with the service-users. Some staff appeared to understand the women's offences in light of their past, often abusive experiences, with their offences being perceived as an

unhelpful means of gaining lost power. This perception could perhaps differ to the conceptualisation of men's offending behaviours and would require further exploration, especially as this degree of understanding and empathy for the women's histories appeared to shape the establishment of the therapeutic relationship, and the initiation and nurturing of recovery. Participants described aspects of the 'secure base' category, such as the creation of a homely environment, as being pertinent to women. Staff aimed to provide an environment in which the women could fulfil an array of roles that they were presumed to have fulfilled in the past, such as homemaker. Furthermore, the fulfilment of these roles provided a means to enable and empower the women as they worked towards future-orientated goals. The homely environment also provided a safe place to facilitate family contact, which was considered important for women.

At times staff distinguished between PD and mental illness, predominantly in relation to the nature of the therapeutic relationship and in the initiation, in particular the timing, of the recovery process. Some staff reported that the recovery approach was possibly most suited to individuals diagnosed with PD given the reliance on collaborative relationships in which responsibility was shared.

The results are described according to the categories and their sub-categories, exemplified through anonymised participants' (P) quotes.

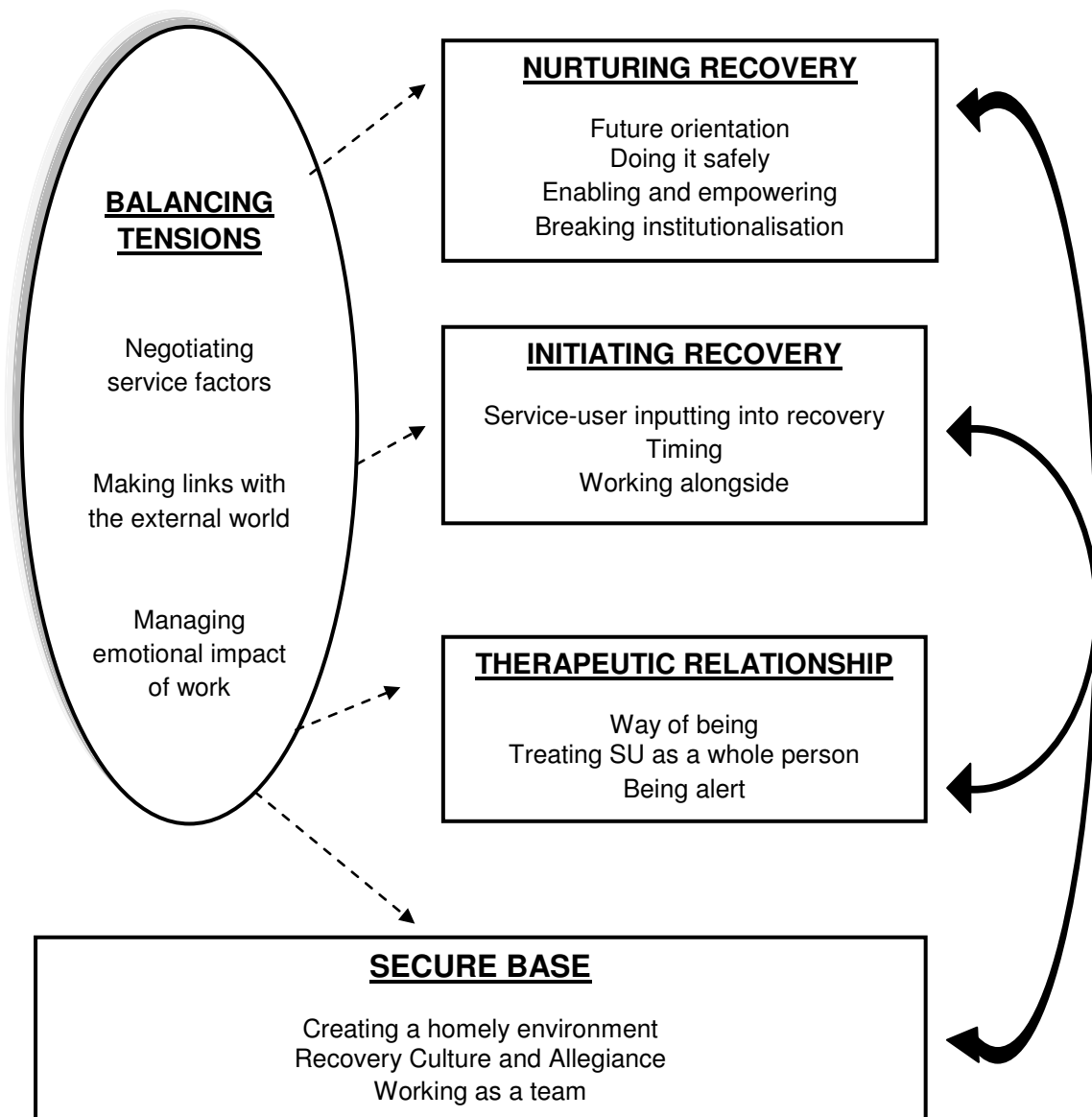


Figure 1. Preliminary model of applying a recovery approach with women with a diagnosis of personality disorder in secure care.

Category 1: Balancing Tensions

A strong theme that emerged was the continual negotiation of a number of tensions that originate throughout an individual's recovery process. These tensions are created through a range of sources, which may not always be experienced as supportive of recovery and can lead to conflicting priorities and feelings of frustration and despondency. Staff spoke of repeatedly weighing containment for security reasons versus emotional containment for therapeutic reasons. Different phases through the recovery process can pose different

challenges, which may require a return to the secure base or the therapeutic relationship to restore the recovery progress.

“it’s about giving people opportunities to prove themselves and if you limit those...you’re restricting them and deskilling and institutionalising people” (P:5)

Negotiating service factors. Participants identified a number of factors within the secure environment, and practice guidelines or directives from the NHS and/or the Ministry of Justice that can leave them feeling forced to restrict recovery. Staff actively worked to address risk but felt the heightened security emphasis, particularly in the current context, hampered a number of recovery goals, including service-users possibilities for progression.

“if basically all you can base the recovery on is a completely sterile environment it’s not a true picture of how they’ll be able to manage” (P:10)

“how far can somebody achieve recovery...when there are boundaries and structures in place that are preventing them...because it’s political or governmental or Ministry of Justice” (P:5)

Some staff did however see benefit in having a body, such as the Ministry of Justice, removed from the emotional involvement clinicians may develop with service-users, to monitor risk management.

“it’s good to have somebody that is a bit distanced from them, to see the bigger picture than I would be, because you do tend to get...a bit blinkered by being that close to your client, so that can be very useful.” (P:9)

In the process of negotiating these factors, staff sometimes found they were required to fight and advocate for service-users needs.

“the automated system...is not concordant...with a recovery model, because all the auditors want to see...this big care plan that says...‘this person will’ ...I had to fight really hard to keep [service-users’ plans]” (P:6)

Making links with the external world. Participants spoke of a number of external stressors to contend with when supporting service-users accessing or taking up roles within the community (e.g., education). These obstacles entailed factors such as society's negative views of service-users and a lack of resources or community support.

“sometimes setting up links with community resources is difficult, people won't phone you back...and they'll say that they don't feel they have the right training” (P:1)

“you got to a certain point of your recovery that you can move on...but...we don't have anywhere...to move on to” (P:10)

Staff actively attempt to improve links with the community and overcome these obstacles.

“we always try and encourage people...if they've got leave...to do the activity in the community” (P:1)

“if we can educate the client enough, and staff enough, to understand what went wrong...how we're going to mend it...how it's going to be, then we can get most outside agencies running along that line” (P:2)

The impact of these negative external forces can lead practitioners to fulfil quite protective roles for the service-users.

“possibly makes me a little bit more protective...I wonder whether it does affect the way I'm working with people when I know they want to work...whether I'll think more of voluntary work with organisations we have links with first” (P:1)

Managing emotional impact of work. The imposed limitations, and/or direct work with the service-users themselves, could create feelings of fear and anxiety; or a sense of vulnerability within staff. This was influenced by staff's fears of litigation, feeling “stripped of [their] professionalism and...expertise” (P:8) due to directives, and a perceived lack of wider system support for what is required to facilitate recovery.

“But at the back of my mind, if we get that wrong, they’ll come down on us like a ton of bricks...so I suppose it’s instilled a sense of fear in the workers.” (P:6)

“I think more from a kind-of potential litigious...aspect...then there might be more anxiety” (P:1)

These feelings could be amplified through the process of handing power over to service-users during recovery.

“I haven’t ever been challenged as much as I have been here...that is the recovery model and it’s good that [service-users] can speak up...but sometimes it’s hard...sometimes I’ve felt disempowered” (P:8)

“I feel that as staff we can be quite vulnerable because of the recovery model and the fact that the clients can take the lead” (P:10)

Difficult emotions could also be evoked if service-users’ difficulties resonated with staff, which some participants particularly noticed in working with women.

“things sort of resonate a bit more...seeing a woman in distress...reading a woman’s difficult family history... a little bit more than it would with working with the guys...I find that...challenging” (P:1)

Category 2: Secure Base

It emerged that to promote and support recovery a solid foundation is required for both staff and service-users. The base itself constitutes contextual factors, support structures, and a recovery narrative and ethos.

Creating a homely environment. Participants spoke of the numerous recovery benefits afforded by creating a warm unit environment that “modelled normal life” (P:11) in which service-users could contribute to the running of the unit, for example, food shopping. This environment was indicated by some as the most suited to women, based on the assertion that they may have fulfilled roles of ‘mother’, ‘helper’ and home-keeper in the past and thus

were being provided with opportunities to fulfil similar roles again. Furthermore, staff and service-users could engage in shared activities such as eating dinner together. The small size of the unit was repeatedly raised as a positive contribution to this homely environment, facilitated by a number of supportive structures such as weekly house meetings and daily debriefs. It was also considered important to facilitate peer support among the women.

“a lot of meetings...it is about just checking in with them all the time” (P:8)

“therapeutic community...and it does seem to work in smaller units...in that people learn from each other” (P:9)

“set up a kind of pseudo-family, but, a lot of people are just trying to recover from their family...so a lot of work’s done through that.” (P:7)

Participants highlighted the need for facilities, and resources such as “family interventions” (P:5), that could support family contact in the unit. Yet they also acknowledged the tensions this can create as some family members may feel unsafe or service-users may “lack pro-social networks” (P:11) where short-term separation from family dynamics could be perceived as conducive to an individual’s recovery.

“maintaining family links...is so important...especially if there’s children involved...if that role was denied them and they could then get a sense of having that role back again” (P:6)

Recovery culture and allegiance. Participants spoke of how signing up to a recovery ethos, that was embedded in the culture and language of the unit and supported by management, made the promotion and maintenance of a recovery approach possible.

“comes down to the culture of those in charge and how much they want to link in with...the recovery model...and the importance that it’s placed...if it was so ingrained from the very beginning, that was just how it worked” (P:11)

“within the culture, it’s within the language, it’s all areas of care really” (P:1)

To maintain this recovery culture, participants spoke of the benefits of having a “resident consultant” (P:1) and “recovery buddy” (P:2) to monitor adherence.

Working as a team. Participants emphasised the value of team-working to support recovery practices. In order to work well as a team participants described the need to manage the work’s emotional impact, be that personally or at a team level. This is supported through the availability of regular training, supervision, reflective spaces, staff monitoring self and each other, and drawing on the team’s different skills. Some staff did point to differences that may occur within the team due to differing perspectives on recovery or due to some staff’s position in either holding greater professional responsibility for risk or the safety of both junior staff and service-users.

“difficulties were when another staff member didn’t agree... or their own personal stuff became mixed up with the resident...then splitting occurred” (P:11)

“we’ve got such good support networks...we’ve got a reflective group...individual supervision...outside of that you can call a psychologist and...personal supervision...that’s how I keep my boundaries...by processing what’s going on...looking at that and trying to keep aware and professional” (P:7)

“If everybody had proper training...we don’t all necessarily have to think the same but if everybody has an understanding of it then...we would all be on the same...page” (P:4)

“make a good contingency plan...make a thorough assessment and check it out with other people in the team...not be the only one...who knows it all...we all have different areas of expertise.” (P:8)

Category 3: Therapeutic Relationship

Participants emphasised the significance of trusting and collaborative therapeutic relationships with service-users as the medium through which recovery can be actualised.

“as the relationships grow...it becomes a more natural balance to it...that’s when they’re feeling safe” (P:2)

“it’s the staff and the client working well together...having, that relationship...if that wasn’t in place, the recovery plans and working towards the recovery wouldn’t necessarily work” (P:3)

“Building up therapeutic relationships...is really key to that process...that can...enable people to say...actually there is a bit of hope” (P:11)

In maintaining these therapeutic relationships, some participants also referred to needing to explicitly work with the roles that service-users may consciously or unconsciously put them in at times.

“No matter what relationship they put you in...you have to ride with it sometimes to see what they giving you...and just slowly bring other people in” (P:2).

Way of being. Staff’s way of being was defined as a human approach to care that a majority of staff described as resonating with their own personal way of relating and with the core principles of their profession. This entails openness, honesty, being non-judgemental, and being empathic all of which were considered important in developing, and sustaining, therapeutic relationships that offer a sense of constancy.

“it’s not all going to be positive, but it is honest and I think then that does make relationships that are quite trusting...I feel that it just enhances that relational security and the recovery model.” (P:8)

“it’s good to have a non-judgemental approach...a good attitude is knowing...that we are all human and...we’ve all got our needs...if you were given those set of circumstances, how differently would you have acted...just a general interest in people, really.” (P:7)

Treating service-user as a whole person. Participants emphasised how their person-centred approach to service-users as unique individuals beyond diagnosis, offence status, or gender was vital in developing therapeutic relationships. Participants tended to understand service-users' presentations, particularly women's presentations, in light of their past experiences, which often entailed disrupted, traumatic and/or abusive relationships. This understanding elevated participants need to attend to the establishment of secure relationships in order to support recovery.

“the principles of recovery...treat a person as you would want to be treated...hear a person as you would want to be heard” (P:2)

“comes down to how the staff view that individual...how they work with them...that really impacts on how the resident holds their own recovery in mind.” (P:11)

“to get more support in their recovery, in terms of the offences that the women have committed, I think it's a...cry for help” (P:1)

Participants also highlighted the importance of not imposing or assuming an understanding of service-users' difficulties but rather aimed to explore this with service-users.

“mentalizing where that person is at...where they've been...understanding their story, understanding the context to their life...then understanding where it is they want to get to and then helping them on that journey.” (P:7)

Being alert. In sustaining healthy relationships, participants spoke about the need to be alert to not only service-users' nonverbal communications but also to their own and the team's ability to remain boundaried and consistent in their approach. An ability supported by the secure foundation of supervision and sufficient staff-to-client ratio.

“we have to be picking up on the subtle signs...having to get to know that person and getting them to know us is really important...with a lot of our women, you can see or

feel even when something is not quite right...you can get a conversation going from there.” (P:10)

“boundaries...it gives a sense of security not only for the client but also for the staff member...it’s a consistent approach...very important within the recovery model” (P:6)

“a team approach, so that those boundaries are in place...you’re all aware of those boundaries, the woman’s aware of them, you’re aware of them” (P:6).

“Physical safe environment for them...where...we can be particularly observant...to their own physical threat...psychological support...enough staff on for them” (P:2)

“you do know other things that are happening with other residents and how they’re feeling and you may know about how a particular member of staff is perhaps struggling with something...so there’s a lot of things that you’re watching out for...that you’re having to juggle” (P:8).

Category 4: Initiating Recovery

It appeared that a number of personal and interpersonal factors influenced when or how an individual’s unique recovery journey would begin.

Service-user inputting into their recovery. In order to facilitate the recovery process participants conveyed how staff needed to give responsibility to the service-users and jointly focus on what was important, rather than impose staff’s goals. Service-users are positioned as experts in their care yet staff also empathised that this could inadvertently pressurise service-users to recover, and thus were required to gradually enable service-users to manage the degree of responsibility.

“the best way for people to recover, to get well...to improve...is by having to make sure they have some input in their care...make it theirs...it’s far more...successful than...telling them what and how to do stuff” (P:9)

“handing over their recovery to them...which can be quite a daunting experience for some” (P:10)

Timing. Timing referred not only to establishing when may be the most appropriate time to begin the process but also referred to participants’ empathetic recognition of the length, and sometimes arduous nature, of the recovery process for service-users.

“Time...staff can give them time...staff not on a time constraint.” (P:2)

“it takes a good long time to undo damage that’s already been done” (P:6)

There was also an awareness of the enforced length of time that staff and service-users had together. There appeared an ambivalence regarding the therapeutic value of an extensive time together versus a sometimes unnecessarily extended time due to perceived risks or resource constraints.

“a very...slow process sometimes...I suppose that’s the beauty really...of working with people in secure services...you generally work with them for a minimum of two years...you...slowly modelling the...positive sides of recovery” (P:11)

“she’d actually manage very well in...low-secure...but because of the section that she is on and the constraints of the Ministry of Justice...it’s going to take an awful long time” (P:8)

Participants differentiated between the recovery process and the end goal of recovery, and how this was influenced by the secure environment, acute mental illness, and service-users’ stage of recovery. The stage of recovery was influenced by service-users’ motivation and desire for change, shaped by fears of what progress might entail. Some staff reported that a recovery approach was possibly most suited to individuals diagnosed with a PD given the reliance on collaborative relationships in which responsibility was shared. Thus, assuming an ability or understanding that may not be believed possible when a person is acutely unwell.

“someone diagnosed with a mental health problem...in the really severe, acute phases, you have to protect them...once we get them out of that phase...it’s imperative that we bring the recovery in, so that they’re being educated...they’re understanding the whole process” (P:3)

“it comes down to the stages people are at and how much people want to move forward and think about change” (P:11)

Working alongside. Staff emphasised that initiation of the recovery process was personal to each service-user and required staff to patiently work at their pace, to gradually enable and empower them to take the lead in their recovery. Staff appeared to value the uniqueness of each of individual, highlighting the need to tailor their approach and recovery plan in a client-centred manner. This approach could at times evoke feelings of unease in staff by being led by service-users as they fought not to rush the process or felt at times they may want to slow the process for the service-users’ sake.

“you all need different times to heal and not to rush that...because you belittle their experience and by belittling their experiences, you’re being no better than the offender...you need perseverance” (P:2)

“identifying their goals and what they want to achieve and how they going to manage...it’s very personal...it’s meeting up with them and trying to work alongside them really...investing...my hope in them as well” (P:3)

Category 5: Nurturing Recovery

Participants endorsed a number of tasks, goals, and strategies that fostered the recovery process within the environment and towards an aspired end goal of a successful move-on.

“we’re here to help you move on and we’re here to look after you...trying to encourage them with their recovery is essential...with working, daily with them” (P:3)

“I kind of started to get the notion of how recovery wasn’t just about within the unit...it’s about how to help people get used to life in the community” (P:11)

Future orientation. The participants described experiencing a number of conflicts as service and external constraints became increasingly more pronounced as future move-on goals are negotiated. To make recovery possible it relied on staff’s ability to remain positive and being able to instil hope in service-users.

“the women have to do certain things to be able to move on... to meet the requirements of the Ministry of Justice” (P:1)

“the main goal is to get somebody into a position where they can move on...can feel that they’re getting better...can regain a sense of themselves and their lives rather than other people making those decisions for them” (P:5)

“for them to look forward...have a little bit of hope about the future and that ‘I’m not going to be stuck here necessarily...there’s people around to help me...I’m not to be abandoned or rejected” (P:11)

Instilling hope entailed service-users realising their own potential to progress:

“in order for people to move on...they need to progress and they need to see progress and sometimes that situation doesn’t allow that progress, or very little progress” (P:9)

Enabling and empowering. A strong theme that emerged was enabling and empowering service-users through their recovery. This entailed focusing on their strengths and developing their skills and confidence through education, enhancing their understanding and having viable opportunities in the environment.

“focus more on people’s wellness rather than people’s illness and help them...look more to the here and now rather than the past...move along from...things that happened in the past, and get...input from them” (P:9)

“the residents planning together...developing budgeting skills...and developing their

self esteem...because even if food is not that good...the others give positive feedback so that their self-confidence can grow” (P:9)

Doing it safely. Participants defined their role in working collaboratively with service-users to help them recover safely. This may at time require staff to impose safe limitations or by grading different activities and breaking them into small achievable tasks. Possible problems are anticipated and clearly planned for. The planning is done jointly with service-users, and shared as a multi-disciplinary team.

“see what they have to say...how they do...if we don’t realistically believe that it is the pathway to recovery for them...to negotiate with them and maybe help them filter a better way.” (P:2)

“sit down with the person...work out with them how they’re going to achieve each of those objectives...graded exposure” (P:6)

Breaking institutionalisation. A large aspect of nurturing recovery entails offering the service-user choice and support through the process but also knowing when to step back and allow the service-user to take responsibility and positive risks. There is a clear recognition that the offering of choice may be overwhelming for service-users initially, as a result of their personal histories and history of contact with services that may not have facilitated independence in the same manner.

“recovery can instil fear...a lot of the women...have been unwell for years...have never learned to take responsibility...been given the opportunity to take responsibility...but...recovery is a positive phrase and can instil hope.” (P:6)

“the patient feels in control of their...recovery...their illness...they understand something which was probably...fear through a complete and utter lack of understanding of why...so the educational part for them to understand that...to have

control over maybe changing the pathway...to be able to make someone feel comfortable and secure in choices...the recovery model does that” (P:2)

Discussion

The study developed a preliminary theoretical model for understanding the way in which staff perceive and apply recovery approaches in work with women with a PD in secure care. The findings pointed to a number of tensions that staff are required to balance throughout the recovery process. Some of these were similar to the tensions highlighted in Mason’s (2002) literature review: staff’s negative and positive views, security versus therapy, and training and cultural formation. However, the tensions regarding violence management and therapeutic efficacy did not appear to be as prominent within this sample. In this study, the nature of the tensions seemed to change during the recovery process, dependant on what was required during the initiation or nurturing of recovery. Participants readily accepted and acknowledged the arduous nature of recovery and understood the time required, based on their empathic understandings of the service-users’ pasts. This degree of empathy appeared to be made possible by staff identifying with women’s past difficulties and by understanding some women’s offences as a “cry for help” (P:1) or means of “empowerment” (P:2). This may differ to conceptualisation of men’s offences and requires further exploration.

The model suggested that establishment of the secure base is of vital importance for both staff and service-users to foster and explore recovery. This is in line with Adshead’s (1998) attachment framework for supporting recovery in forensic settings, similarly promoted as a key ingredient in therapeutic communities to support a culture of belonging (Haigh, 1999). The preliminary model arguably extends these concepts by emphasising that the need for a secure base relates not only to the function of therapeutic relationships but also to what staff require in order to promote recovery. Bowlby (1988) conceived that a secure base extended beyond interpersonal relationships but was crucial to aid children and adult’s

exploration as they returned to it from time-to-time. Staff appeared to need to continually maintain and reaffirm their secure base throughout the recovery process to aid their navigation through challenges that conflicting tensions could create. The participants highlighted the number of valued support structures within this secure base, such as supervision to manage the emotional impact of the work. Challenges associated with working with people with PD have been widely discussed, alongside the need to ensure that staff receive appropriate support and supervision (Bateman & Tryer, 2004b). However, in this context the support extended beyond this, and included attending to the sense of vulnerability and uncertainty that arises through balancing inherent tensions, and by being led by service-users through the recovery process.

The supportive function of a strong team, allied to a recovery approach and surrounded by a recovery culture, is in accordance with Bowers et al.'s (2005) findings, indicating that units with a consistent and clear philosophy and treatment regime maintain a positive attitude among staff. This shared understanding and desire to promote recovery appeared to foster a climate in which participants recognised the value in being alert to themselves, each other, and service-users' behaviours, to maintain a good team and therapeutic relationships. Contrary to Kurtz and Turner's (2007) finding that forensic staff expressed a fear that commenting on a colleague's approach might be regarded as attacking, participants in this study encouraged open communication about difficulties. This culture of openness is also a key component of therapeutic communities as purported by Haigh (1999). Staff highlighted value in addressing what at times could be unconscious processes, in order to establish healthy, honest relationships in which staff role-modelled a means to manage difficulties in interpersonal relationships. This was supported by adequate supervision and reflective space that endorsed the consistent approach necessary to support recovery. This is similar to the factors which Kurtz (2002) identified as contributing to a sense of emotional

safety: the creation and maintenance of boundaries between staff and patients to protect therapeutic space; and the monitoring, naming and regulating of affect in staff and patients to promote the capacity of patients to think about and understand themselves in relation to other people. An approach comparable to that used in mentalization-based treatments for PD, with the aim of enhancing an individual's sense-of-self in relation to another (Allen & Fonagy, 2006) and thus suggesting forensic services' capacity to support identity formation which is considered important in the recovery literature (Onken et al., 2007).

However, there was an acknowledgement of possible differences in opinion among staff regarding recovery and positive risk-taking which may point to multidisciplinary differences as highlighted by others (Pouncey & Lukens, 2010; Summers, 2003) or possibly due to lack of service-specific recovery training. Although 7 of the 11 participants reported to have had recovery training, the majority of this was not necessarily PD or secure-unit focused, with staff mainly learning through working on the unit. Gudjonsson et al. (2010) found that recovery training had a positive effect on forensic staff's beliefs about the feasibility of recovery approaches with detained and PD patients, thus highlighting the utility of training in enhancing staff's secure base.

Despite an indication of some possible differences in opinion regarding recovery, depending on seniority, it would appear that this study's findings support and extend Grounds et al.'s (2004) survey findings from lead clinicians in 36 medium secure units. In particular, their description of the characteristics of well-functioning units as including: good staff relationships, multi-disciplinary work with shared aims/philosophies, prioritising patients' needs, and adequate staff-patient ratios; with a central emphasis on the qualities of the staff.

The model suggests that a recovery language as part of a recovery culture, alongside the focus on the future and service-users' strengths, can support and nurture recovery in this context. Similarly, the positive change in culture post-implementation of the tidal model in a

mixed medium secure unit was said to engender feelings of hope and optimism in both staff and service-users (Cook et al., 2005). The power of language and positive expectations have long been observed in the forms of placebo effects and self-fulfilling prophecies (Miller, Duncan, & Hubble, 1997). This can be explained according to complexity theory, which posits that individuals conform to role expectations and resist overt or covert means of control or manipulation (McCrone, 1999). These ideas are akin to the description of the change process in narrative therapy that involves helping clients replace their restraining problem-saturated narratives with more preferred, and subsequently more empowering, stories about their problems and lives (White, 2000). A task supported through the staff's approach to individuals as unique and not defined by diagnosis or offence status. The findings links to attachment and narrative theory propose that application of recovery approaches in this context may be supported by drawing on the principles of attachment narrative therapy as described by Vertere and Dallos (2007).

Concordant with the recovery research (Caldwell, Sclafani, Swarbick, & Piren, 2010), collaborative, trusting relationships were noted to be the most important vehicle for change during the recovery process. Similar to the 'levelling' within staff-service-user relationships encouraged by the tidal model (Barker, 2001), participants spoke of giving over power, choice, responsibility as they attempted to work alongside service-user's in a client-centred manner. It has been suggested that this shift in power enhances service-users' sense-of-self and connectedness in relationships, with these changes being noted by forensic service-users as positive for their recovery (Cook et al., 2005). These relationships were said to be supported by the small, homely environment of the unit which enabled sharing of tasks and 'normal' interactions between staff and service-users. In a qualitative study, service-users with a diagnosis of borderline PD, emphasized how the establishment of trust within therapeutic relationships engendered hope (Langley & Klopper, 2005). The significance of

hope within recovery is extensively highlighted in the recovery literature (Stickley & Wright, 2011b).

These communal roles within the unit also provided the opportunity for skill and self-confidence development, thus gradually enabling and empowering service-users. Developing agency within the service-users appeared to be supported by the staff's understanding of the service-users' difficulties and fears regarding move-on and hence staff's tentative approach when offering choice and responsibility in order to break institutionalisation. Themes that are concordant with therapeutic community principles of involvement, agency, and containment (Haigh, 1999).

Bowers' (2002) research with nurses working in high secure hospitals highlighted how some mental health professionals sustain a positive approach to individuals with PD, by belief in the uniqueness of the individual and their problems; commitment to values of honesty, equality, and personal value; cognitive and emotional self-management; mastery of interpersonal skills; teamwork; and organisational support. All of these factors emerged from the data in this study highlighting their significance in promoting recovery with women with PD in secure care.

Limitations

One limitation of the study was the use of opportunistic sampling as participants were drawn from one unit. There was also potential for self-selection bias that may have resulted in participants who had strong views about recovery and were more willing to share these. However, the study did attempt to capture the range of views through constant comparison within and across data.

The study aimed to develop a theory of how staff in this particular context understood recovery and as such their understanding would be shaped by their context. This study intended to develop understanding rather than be generalized to all medium secure units. The

description of the unit itself and study participants allow the reader to explicate what may be applicable to other contexts and enhance the findings transferability. The study is however limited in that it did not include the full range of multi-disciplinary personnel that work in these units. The data itself pointed to potential differences between staff; those with seniority and/or more responsibility for risk-management may hold a different perspective on balancing the tensions inherent in the task of applying recovery in this context. This may need further exploration. Furthermore, this study relies on staff perspectives of recovery which may differ to service-users' perspectives, as indicated in the recovery literature (Stickley & Wright, 2011b), and thus would benefit from triangulation with service-users. However, an attempt at triangulation was made through incorporation of research exploring forensic service-users' perspectives.

Implications and Recommendations

The highlighted need for a secure base in balancing tensions while exploring recovery in work with women with PD in secure services, points to a number of service and clinical implications. The small size of the unit was frequently referred to as a positive factor in establishing and maintaining a secure base and therapeutic relationships, and the homely environment fostered service-users' involvement in the running of the unit. These factors were supported by a good staff-to-client ratio, allowing for the time required to form trusting relationships and ensuring consistency in the teams approach to care. The recovery culture of the unit was also supported by a number of factors which services could consider incorporating, such as a recovery buddy or resident consultant, to monitor compliance to a recovery approach. Additionally, incorporation of structures such as regular service-user meetings to aid monitoring and peer support. Unit facilities for family contact and resources, such as family interventions, to foster development of healthy relationships with family outside of the unit appeared beneficial.

The findings point to a number of theoretical frameworks that may be helpful in supporting the application of recovery principles in secure units, through the attainment of recovery outcomes linked to identity, relationships, empowerment, hope and optimism. These included therapeutic community principles (Haigh, 1999), attachment (Adshead, 1998), narrative (White, 2000) and possibly mentalization-based (Allen & Fonagy, 2006) frameworks.

The value of supervision and a reflective space was regularly referred to as a positive means to support staff and the team working well together. This reflection not only requires an open space where staff can feel comfortable to express emotional reactions to the work, the client, and the inherent tensions, but also a need to address the feelings of uncertainty that using a recovery approach may evoke. To sustain a recovery culture, support is required from senior management with an open means of communication between frontline workers and management.

Additionally, in order to foster the use of a recovery language and shared focus among staff, all staff may benefit from recovery training; particularly training that attends to the tensions inherent in this environment. Further research may be required in not only establishing the transferability of these findings to other, possibly larger or male, secure units, but also in evaluation of tailored training programmes.

Conclusion

The study developed a preliminary theoretical model for understanding the way in which staff perceive and apply recovery approaches in work with women with a PD in secure care. Staff's role within this process has been elaborated, particularly in relation to establishing and maintaining therapeutic relationships, initiating recovery, and nurturing recovery. This research highlights service and environmental factors that support the

fostering of recovery in this context, including the support staff require to navigate the inherent tensions through the process.

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Section C

Critical appraisal and reflection about the study

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1953 (plus additional 223 words)

Critical Appraisal and Reflection about the Study

The aim of this paper is to provide a critical appraisal of the study. This will include reflection on the process of the conducted study as well as what has been learnt in terms of research and clinical practice.

Research Skills and Abilities Learnt and Developed

Initially, when attempting to devise research methodology, I spent considerable time identifying what qualitative method of analysis to utilise. I learnt that the answer lay in focusing on formulating clear research questions and then finding the method best suited to answer them. I had considered both Interpretative Phenomenological Analysis and grounded theory (GT) methodologies applicable for this type of study. This study aimed to explore an area that had limited related literature in order to generate a vivid account of staff perspectives and their understanding of applying recovery, rather than focus on the nature of the experience for staff. The possibility of theory production in GT that could describe the process of recovery, including a conceptualisation of the links between themes, was concordant with these study aims. The model could then, as Starks and Trinidad (2007) argue, not only inform practitioners, but also researchers, services, and policy makers by providing a base for further exploration with an understanding of what is required to support recovery in this context. Through further reading and discussion with supervisors, I also came to learn that GT was possibly more suited due to the heterogeneity of the sample (multidisciplinary staff that literature suggested may have different views on recovery).

Undertaking the analysis, and discussing this in meetings with fellow GT researchers, enabled me to gain a good, in depth, understanding of one qualitative approach. I also learnt how a qualitative analysis package, namely NVivo, could provide great assistance in managing the data during focused coding. However, I would benefit from further training in how to use the package's full capabilities, particularly in later stages of analysis. Through the

analysis I came to learn how invaluable the research diary and memo writing were in maintaining reflexivity. I was also surprised by how much it helped in producing the written results section when I mainly needed to sort and expand on earlier memos. I found GT a time-consuming form of analysis, in comparison to a thematic analysis that I had used in the past, yet it did provide an in-depth understanding of the data and my use of its techniques assisted the iterative generation of theory. However, I experienced being overwhelmed with data and there was a struggle at times to step-back and provide an analytic overview of the data. In the future, I would want to develop my knowledge further of other qualitative methods and in utilising mix-method designs.

I had found the literature review a challenge due to the breadth of material that could have been included which the word limit did not permit. I subsequently needed to refine my skills in selecting the most pertinent information and in being concise. I would have also greatly benefitted from using a reference manager package as I spent considerable time on organising references.

Undertaking semi-structured interviews and listening to the recordings afterwards enabled me to enhance my interviewing skills. I was progressively more able to maintain the structure while simultaneously attending to the natural flow of conversation and building rapport with the participant. I also became aware of how nervous some participants were about being recorded and feeling 'tested' on their knowledge, which I would attend to more explicitly in the future.

By undertaking this research in the National Health Service, I have come to develop a more realistic understanding of the ethical process and of the time that should be allotted to recruitment, ethical approval and qualitative analysis. When designing the research study, the possible influence on the research of the supervisor being a member of staff in the unit had been considered with both supervisors and the NHS ethics panel. We considered the

possibility that staff may have felt obligated to participate given the external supervisor's involvement in the study. On the other hand, it was possible that staff might refuse to participate due to concerns about what the external supervisor may become privy to, and thus affect the confidentiality and anonymity of the interviews. Subsequently, when I introduced the study to participants I explained that all interviews would be anonymised. Thus, I would be the only person who knew the personal details of the individuals who participated. During the analysis, the internal supervisor had access to anonymised transcripts whereas the external supervisor only had sight of anonymised quotes at the later stages of the analysis. This aimed to not only preserve participants' anonymity but also to reduce the external supervisor's possible bias as an 'insider' who may have had her own strong views about recovery in this context. Therefore, in order to reduce the possible impact of the external supervisor's involvement, participants were made aware of these safeguards in the presentation of the study to the unit and they were also detailed in the information sheet provided to participants.

Despite consideration of ethical dilemmas at the proposal stage, I came to realise how many small issues became apparent throughout the research process that require careful consideration to ensure ethical practice. For example, I allowed people to volunteer to participate via email, but when arranging an interview time, some participants gave reasons for being unable to commit and then did not get back to me. Even though I was keen to recruit, I felt I had to accept this as their withdrawal and did not chase them about it. Another ethical dilemma that arose was the use of a professional transcriber. I had not anticipated the degree of some participant's details about service-users' self-harm/abuse/offence history which I recognised may emotionally affect the transcriber. As such, I only sent recordings that did not contain any vivid or detailed descriptions and offered debriefing after every interview, even though this was declined. It was also evident how important and helpful it is

to have research peers and supervisors throughout the process to support ethical practice, quality assurance and to sustain motivation throughout the process.

What Would be Done Differently if this Project was to be Repeated.

The study may have been improved by a different recruitment strategy to facilitate the inclusion of a wider array of multidisciplinary staff. From a theoretical sampling perspective, the data suggested that staff who held more clinical or managerial responsibility may have had different views on recovery or how to manage the tensions. Therefore, the data may have been enriched from inclusion of more senior staff, to explore this further. This could have been supported by presenting the study at more than one staff meeting and identifying other types of meetings that the wider staff group attended. Furthermore, telephone interviews, as an alternative to face-face interviews, could have been offered to enable more time-constrained staff, and staff that did not work exclusively on this unit, to participate. However, staff experience and training was considered during the analysis by identifying any differences and then retrospectively and prospectively comparing them across the data. Some of the findings were also triangulated with survey findings of lead clinicians in medium secure units.

The findings' credibility may have been strengthened through greater use of member checking (Mays & Pope, 2000). The initial ethics proposal for this study included post-interview focus groups in order to explore the emergent findings further. However, this was removed due to an ethical concern, regarding the impact of feeding back interview findings to a small team who may recognise each other's quotes and who may not want to contradict each other in the group. This concern was substantiated following the team presentation, where staff commented how they would be interested to see how different members responded and how they would 'know' each other's quotes, despite my explanation of confidentiality and anonymity. Member checking was thus only completed by sending

preliminary findings by email to participants, and a shortcoming may have been that I could only provide a limited time period for response due to the thesis deadline. This method of engagement arguably requires more commitment from participants, and the summarised feedback did not necessarily offer detailed explanation of the categories. This was evident in some participant feedback that requested elaboration. Therefore, it may have been beneficial to allow greater time for validation that could have been achieved through conducting second interviews with participants (Charmaz, 2006) or by providing final feedback at a team meeting that allowed for clarification of categories and gathering of written confidential feedback. There were, however, additional approaches used in this study that enhanced the credibility of the findings, such as the use of the constant comparative method, comprehensive data treatment, and deviant-case analysis (Silverman, 2000). These validity approaches are considered cognisant with a constructivist paradigm, as utilised in this study (Creswell & Miller, 2000).

The study may have benefitted from inclusion of other women's medium-secure units to allow for further exploration of some of the categories, particularly if larger units were recruited, as the findings highlighted the benefit of a small unit in creating a homely environment. However, the recruited unit was selected as it was known to explicitly use the recovery model, which allowed for a comprehensive contextualised understanding of recovery in practice. In consultation with the supervisor, who worked on the unit, it was believed that recruitment would not be problematic and that an adequate sample size could be achieved. The time constraints of conducting doctoral research would have inevitably restricted the number of participants that could be interviewed across a number of sites. Although 11 participants is a relatively small sample size, it did appear that there was sufficiently substantial and rich data gathered that adequately fleshed out the categories to reflect the depth and complexity of the recovery process in this context. Williams and

Morrow (2009) point to these factors as evidence of theoretical saturation. However, replication of this study in other women's secure units would be beneficial. Furthermore, units that do not explicitly use the recovery model could be included to explore what may constitute the secure base that enables therapeutic use of relationships towards recovery goals.

What Will be Done Differently Clinically

Two of the core categories identified from the study, the significance of the secure base and the therapeutic relationship, stood out most for me. Firstly, as a therapist, it reinforced the importance of the therapeutic relationship and how many functions a collaborative, open, hope-inducing relationship could serve. I have found this fundamental basic of good therapy to sometimes lose its primacy when as a trainee you are developing proficiency in a range of different therapeutic modalities. Beyond therapy, this research highlighted the importance of all staff-service-user relationships and how psychologists may be best placed to support this through provision of open, reflective spaces in supervision.

Furthermore, in contributing to the secure base for staff, psychologists have a vital role to play in training:

- to ensure all staff share a similar understanding of the team's vision, in this case recovery;
- through knowledge and skill development regarding the unconscious processes that may affect relationships, and how to maintain helpful therapeutic alliances.

During the interviews, as staff shared their views regarding the tensions in the environment, I wondered if their openness was aided by me being external to the unit. I subsequently realise the potential value of having a psychologist external to a team facilitate staff reflective spaces.

Lastly, this research highlighted the significance of therapeutic environments, including incorporation of empowering language, which can support recovery goals. In practise the emphasis is often on supporting service-users establishing valued roles in the community which may neglect what beneficial gains can be made with conducive environments that offer recovery opportunities, be that short-stay inpatient wards or secure units.

Discussion of Further Relevant Research

This study was conducted simultaneously with a colleague studying the perspectives of women with a personality disorder diagnosis in secure care. Hence, in order to develop an understanding of recovery that incorporates both staff and service-users views, it would be beneficial to perform an analysis of the results of both studies. This may provide the opportunity to identify what is most valued and considered helpful from both perspectives. This is particularly relevant as Corlett and Miles' (2010) evaluation found that staff of a medium-secure service consistently rated all recovery elements as more important, and better implemented, than the service-users did.

I believe it would be beneficial to use these findings to inform relevant recovery training, and so an ambitious development would be to replicate Gudjonson, Webster, and Green's (2010) study in women's services. Using a specially designed questionnaire, they investigated the impact of training on staff's knowledge and attitudes about the recovery approach in forensic services. This would entail provision of training, having incorporated this study's findings, to women's secure unit staff. The impact of the training on staff's views would be measured with the questionnaire and this could allow for development of specific secure-recovery training.

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Section D

Appendices and Supporting Documents

Hayleigh Millar

Canterbury Christ Church University

Appendix 1: Search strategy for Section A: literature review

The following electronic databases were searched from inception to May 2011: PsycINFO, Web of Science, Medline, EBM reviews, Cochrane Library, and ASSIA.

Exploded terms were utilised on all databases which included – women, female, personality disorder, secure, offender, forensic, mentally disordered offender, prison, jail, inpatient, recovery, recovery model, recovery theory, tidal model, good lives model, staff, mental health professionals, multidisciplinary staff, nurses, psychologists, psychiatrists, occupational therapists, support worker, perspectives/view/survey of staff/team/professionals. Different combinations of the various terms utilising both and/or functions were utilised through all the databases.

The search strategy was deliberately over-inclusive to prevent pertinent articles being missed. There were no specific exclusion criterion to these searches due to the breadth of the topic.

Empirical studies and conceptual literature were reviewed and evaluated for significance to the application of recovery approaches to women with a diagnosis of personality disorder in secure forensic care. Abstracts were read and articles or chapters/books were sourced as considered relevant to either describing the population group, describing work with the population group and/or staff attitudes/perspectives on working with the population group (either personality disorder or women offenders or combined), descriptions of and/or studies of the recovery model in general mental health services and applications thereof. Reference lists of sourced articles and books were screened for any further relevant papers.

Review of the empirical studies included any studies which looked explicitly at recovery, tidal model, good lives model as stipulated or could be assumed in the keywords or

abstracts as used in forensic services and/or with personality disorder and/or offender regardless of gender. There were no limits set on type or quality of studies. Following review of abstracts articles that directly focused on recovery, rather than only used the term in the title, were sourced.

The review only considered published work restricted to the English language and related to adult mental health. Dissertations were excluded. The review included published articles, books, and policies.

Appendix 2: Instructions for Authors

Further information about the journal including links to the online sample copy and contents pages can be found on the journal homepage.

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form. See the Evaluation Criteria of Qualitative Research Papers and the editorial policy document for more details.

Submissions. All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. **Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting.** Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords. Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association, and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18, 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management*. London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G. Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London: Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Accepted papers. If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00/\$25.00 per copy.

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Appendix 3: Ethics and R&D approval letters

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Appendix 4: Poster**An invitation to participate in research**

Aim of research: Exploring recovery in women diagnosed as having a personality disorder in a secure setting: Staff perspectives

What does recovery mean to you?

What are the strengths and limitations of a recovery based approach?

Does the approach need adapting for women diagnosed as having a personality disorder in secure settings?

What are your experiences of recovery in this environment?

All multi-disciplinary staff working on [REDACTED] are invited to participate in this project. Participation will involve partaking in one confidential interview at a time and place convenient to you.

It is hoped that findings from this research could inform service development and what training or support staff may require to support the provision of user-focused services with this client group.

For more information please see the attached information sheet. Or you can contact the lead researcher – Hayleigh Millar (trainee clinical psychologist) on 01892507673 or email: [REDACTED]; or discuss with [REDACTED] (clinical psychologist, [REDACTED].) who is supervising the project.

Appendix 5: INFORMATION SHEET FOR PARTICIPANTS

Exploring Recovery in Women with a Diagnosis of Personality Disorder in a Secure Setting: Staff Perspectives

I, Hayleigh Millar, am a trainee clinical psychologist currently undertaking a research dissertation as part of a doctorate in clinical psychology at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether you would like to take part or not, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

The research project has been approved by the Local Research Ethics Committee and [REDACTED]

Purpose of study

Recovery is now a widely used term in adult mental health settings. We know that the majority of recovery research has centred on psychosis and schizophrenia, often in community settings. This study aims to explore what recovery means to multi-disciplinary staff working with women who have been given a diagnosis of personality disorder and have been placed in a secure setting. Recovery has different meanings to different people hence this study aims to identify the strengths and limitations of a recovery based approach and will explore whether this is the most effective framework to understand and support women in this specific context. It is hoped that the study will increase awareness of how staff understand recovery and which aspects they find helpful and less helpful, as well as how recovery approaches can be adapted to better meet the needs of this specific client group. It is hoped that findings from this research could inform service development and what training or support staff may require to support the provision of user-focused services with this client group. I would be very grateful for your participation in this project.

What will the research involve?

I will be conducting this research alongside a fellow trainee who will be exploring the same issues from a service-user perspective. The reason for this is that staff/service user relationships have been shown to be very important in the recovery process.

We are seeking to recruit as many multi-disciplinary staff as possible to partake in individual interviews. I will be attending some team meetings at [REDACTED] in order to introduce the research project and myself and to allow you to ask any questions. I will also send the information to staff email addresses. If you decide to take part, you can either contact me, the lead researcher, or give your contact details to [REDACTED], the clinical supervisor of the project. I will then contact you to arrange a convenient time to complete an interview. These interviews will be conducted in the unit or in offices on the same site. The interviews will last 60-90 minutes, which will include breaks or be divided over two meetings if preferred.

Prior to the interview, I will gather some brief demographic details about you, such as professional category, length of time in working with this client group. These details will not be used to identify you individually but will help to establish a broad overview of all the participants of

the research and to what extent the findings from the research will be applicable to other staff working in similar settings. You can refrain from providing this information if you wish to.

The interview asks about your experiences of recovery. What does the term mean to you? What is helpful and unhelpful about this approach? And does the approach need to be adapted when working with women diagnosed as having a personality disorder in secure settings?

The interviews would be audiotaped and then analysed to identify relevant themes across the interviews. Once the analysis has been completed, these findings will be feedback in a team meeting, which you will be notified of in advance. This meeting would allow for your comments or reflections on these findings. If you agree, at the time of interview, then these findings will also be sent to your work email address to provide you with the opportunity to comment on this, either via email or telephone contact could be arranged. Your anonymised feedback will be incorporated into the final analysis.

Your participation in this study is entirely voluntary. If you decide to take part, you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving reason. Participation in the study will not affect your employment in any way.

Confidentiality and anonymity

If you decide to take part, your name and any other identifying information will be kept strictly confidential. I, Hayleigh Millar, will be the lead researcher involved in conducting the interviews and the analysis of these interviews. The taped interviews will be typed up and stored electronically to form a transcript of what was said. Each transcript will be given a unique identifying code and all mentioned names and places will be replaced with pseudonyms. All data on the computer will be anonymised and password protected. The transcript will then be used for the analysis. My academic supervisor employed by Canterbury Christchurch University, Dr John McGowan, will be involved in supporting the initial analysis of these anonymised transcripts. The feedback from the findings will be treated in the same confidential and anonymous manner as transcripts.

In the write-up of the research for university and publication purposes, extracts from the interview transcripts may be included. These will not contain identifying information and pseudonyms will be used. My clinical/research supervisor, [REDACTED], will have sight of anonymised extracts during the analysis to aid the development of a theoretical model about recovery with this client group. [REDACTED] will not have access to the full transcripts at any stage of the research process, and she will not be involved in the initial stages of analysis.

The transcripts and tapes will be stored in a locked cupboard. The tapes and computer file of your transcript will be erased after the work has been completed. The anonymised transcripts will be kept in locked storage in the Department of Clinical Psychology up to 10 years after the research, as is required by the university. The results of the research will be written up for a university academic submission and for publication in an academic journal. In the write-up of the research, extracts from the anonymised interview transcripts may be included.

The only circumstance when I would have to inform others of your participation in the study was if there were concerns raised during the interview about risk to yourselves or others. Confidentiality may be broken if any issues of professional concern in line with the Trust guidelines were picked up during the interviews. These concerns would be discussed with you during the interview, and arrangements made to discuss these concerns with necessary line managers. Should these not be resolved during the interview the lead researcher may consult with the supervisors of the project – [REDACTED], Clinical Supervisor and Dr John McGowan, Academic Supervisor.

Should you at any point after this wish to discuss issues raised by your involvement in the study, a message can be left for me on 01892 507673 and I will be happy to call you back.

Contact details

Please feel free to contact me if you have any further concerns or queries:

Hayleigh Millar, Clinical Psychology Programme, Dept. Of Applied Psychology,
Canterbury Christ Church University, Broomhill Road, Tunbridge Wells, Kent TN0 3TG
Tel: 01892 507673.

If preferred, participants could talk to [REDACTED], psychologist, employed by [REDACTED], who is supervising the research project.

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal NHS complaints mechanisms are available to you. These details are:

Customer Relations

[REDACTED]

Tel:

[REDACTED]

Email:

[REDACTED]

Thanks for taking the time to read this.

Appendix 6: PARTICIPANT CONSENT FORM**Exploring recovery in women, in secure settings, who have been given a diagnosis of personality disorder**

Thank you for agreeing to take part in the above study. Please read the following statements and sign and date underneath if you are happy to do so. Tick each one as follows:

- (1) I have read and understood the information sheet and I have been given a copy of this to keep. The nature and purpose of the study have been explained and I have had the opportunity to ask questions.
- (2) I understand that the individual interviews will be tape-recorded. I understand that the individual names and other identifying information will be removed during the transcription process. I understand that the tape recordings will be kept in a locked cupboard and will be erased after the work is completed. The computer file of the transcripts will be password protected and stored in a locked cupboard for 10 years. I understand that the findings of the study may be written up for publication in an academic journal and, due to usual journal requirements, a paper copy of the transcripts will be kept for up to ten years in a locked cupboard.
- (3) I understand that my name and the organisation that employs me and any other information I provide will be treated as strictly confidential. In the eventual write-up of the research, no identifying information will be presented. I understand that anonymised extracts of the transcripts may be included in the written report of the research.
- (4) I am aware that confidentiality may be broken if any issues of professional concern were raised during the interview. I have read the information sheet in regards to this and I have had the opportunity to ask questions.
- (5) I understand that the research data collected during the study may be looked at by other individuals from the research team, sponsor, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data
- (6) I agree to participate in the above study. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.
- (7) I agree to have the findings from the analysis sent to my work email address in order for me to comment on these should I wish to do so. I understand that agreeing to have the preliminary findings sent to my email address does not require me to feedback if I do not wish to.

Name of participant (print).....Signed.....Date.....

Name of witness (print).....Signed.....Date.....

Appendix 7: Demographic Questionnaire

Could you please complete the following demographic information. These details will not be used to identify you individually but will help to establish to what extent the findings from my sample will be applicable to other staff working in similar settings.

(1) Profession: (please circle) Nursing (including nursing assistants)

Allied health professionals (including Occupational therapy; Psychology)

Social services (including social worker; support worker)

Medical (including Psychiatry; SHO's)

Do not wish to state

(2) Approximate length of time working in this profession: (please circle) 0-5 years
5-10years
10+years

(3) Approximate length of time working in this unit: (please circle) 0-5 years
5-10years
10+years

(4) Previous work in secure units?

If yes, please state amount of years and if female/male/mixed units

(5) Approximate length of time working with individuals diagnosed as having a personality disorder prior to working in this unit: (please circle) 0-5 years
5-10years
10+years

(6) Approximate length of time working with offenders prior to working in this unit:
(please circle) 0-5 years 5-10years 10+years

(7) Have you received any specific training in working with individuals diagnosed as having a personality disorder? (please circle) Yes No

If yes, what was the nature of this training? (please state)

(8) Did it include any training specific to women? Yes No

If yes, what was the nature of this training? (please state)

(9) Have you received any training about recovery? (please circle) Yes No

If yes, what was the nature of this training? (please state)

Appendix 8: Semi-structured interview with participants

Thank you for agreeing to take part in this research by being interviewed. This interview will last between an hour and an hour and a half.

Go through information sheet with participant. Confirm confidentiality agreement. Do you have any questions about this?

Go through consent form and obtain signatures.

Complete demographic details sheet.

If you would like to stop the interview, at any point, just let me know. We can stop the interview and you don't have to tell me why.

Begin tape recording

Questions for individual interviews:

What is your understanding of recovery?

Where did you obtain this understanding from?

What is your view of recovery as a concept?

In what ways is this concept helpful or unhelpful?

In what ways is it applicable or not applicable to the work you do?

How does the diagnosis of personality disorder fit with the concept of recovery?

How do you think recovery is supported in the secure unit?

How can recovery best be supported? What is it like to support it in this environment?

How do you think the service-users you work with view recovery?

What do you believe influences recovery (i.e. staff-service-user relationships; service-user to service-user relationships; relationships with outside support or family)?

In your opinion, does anything impact on recovery?

Does positive-risk taking support recovery? If so, how does it support it?

What are the impact of factors external to unit on recovery (such as view of society, link to external support, employment opportunities etc.)

End interview – Thank you for participating in the interview.

Turn off recorder

Debrief

Appendix 9: Confidentiality Statement for Persons Undertaking Transcription of Research Project Interviews

Project title : _Exploring 'recovery' with staff working with women diagnosed with a personality disorder in secure settings

Researcher's name: Hayleigh Millar

The tape or tapes you are transcribing have been created as part of a research project. Tapes may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University College.

Signing this form means you agree not to disclose any information you may hear on the tape to others, and not to reveal any identifying names, place-names or other information on the tape to any person other than the researcher named above. You agree to keep the tape in a secure place where it cannot be accessed or heard by other people, and to show your transcription only to the relevant individual who is involved in the research project, i.e. the researcher named above.

You will also follow any instructions given to you by the researcher about how to disguise the names of people and places talked about on any tapes as you transcribe them, so that the written transcript will not contain such names of people and places.

Following completion of the transcription work you will not retain any audiotapes or transcript material, in any form. You will pass all tapes back to the researcher and erase any material remaining on your computer hard drive or other electronic medium on which it has been held.

You agree that if you find that anyone speaking on a tape is known to you, you will stop transcription work on that tape immediately and pass it back to the researcher.

Declaration

I agree that:

1. I will discuss the content of the tape only with the researcher named on the previous page.
2. I will keep all tapes in a secure place where it cannot be found or heard by others.
3. I will treat the transcription of the tape as confidential information.
4. I will agree with the researcher how to disguise names of people and places on the tapes.
5. I will not retain any material following completion of transcription.
6. If the person being interviewed on the tapes is known to me I will undertake no further transcription work on the tape and will return it to the researcher as soon as is possible.

I agree to act according to the above constraints

Your name _____

Signature _____

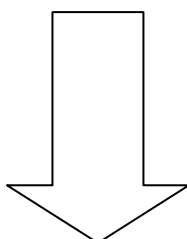
Date _____

Occasionally, the conversations on tapes can be distressing to hear. If you should find it upsetting, please speak to the researcher.

Appendix 12: Illustrating Category Development

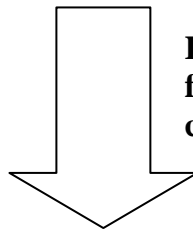
Axial codes (60)

Working as a team	Making links with community	Developing relationships	Planning	Managing complexity – MI and/or PD	Recovery culture and allegiance
Differentiating recovery process vs end goal	Way of being	Balancing tensions	Grading and/or finding alternatives	Working with impact of directives	Working with external influences
Treating SU as a whole person	Exploring with and listening to SU	Working with risk	Working through emotional impact of work	Recognising stigma	Recognising environmental restrictions
Highlighting current context of unit	Breaking institutionalisation	Enabling and empowering	Educating and preparing	Developing skills and confidence	Enhancing SU's understanding
Timing	Initiating recovery	Being led	Working alongside	Tailoring to the individual	Being client centred
Valuing uniqueness	Positioning of SU	Empathising	Observing and monitoring	Recognising emotions	Focusing on strengths
Focusing on the future	Communicating	Instilling motivation and hope	Offering support	Offering choice	Normalising
Defining staff role in recovery	Influencing SU	Making it theirs	Feeling pressured to recover	Inputting into recovery	Identifying what needed from SU
Helping SU do it safely	Restricting and enforcing	Creating a solid foundation	Creating a homely environment	Highlighting size of unit	Sharing
Developing trust	Collaborating	Maintaining boundaries	Maintaining consistency	Moving on	Working with therapeutic relationship



These were developed to 18 theoretical codes (and subcategories)

Balancing tensions	Making links with the external world (3)	Working with emotional impact of work	Negotiating service factors (3)	Managing risk (2)
Recovery Culture and Allegiance	Working as a team	Creating a homely environment (4)	Treating SU as a whole person (3)	Being alert (4)
Staff way of being (3)	Service User inputting into recovery (4)	Working alongside (4)	Timing (3)	Doing it safely (5)
Enabling and empowering (4)	Future orientation (3)	Breaking institutionalisation (2)		



Leading to the final five categories

Final categories (and subcategories)

Balancing tensions(4)	Secure base (3)	Therapeutic relationship (3)
Initiating recovery (3)	Nurturing recovery (4)	

Appendix 13: Transcript examples per category and sub-category

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Appendix 14: Preliminary results feedback to participants

Recovery with women in secure care diagnosed as having a personality disorder: Staff Perspectives - Draft Results Summary (not for wider distribution)

The results suggest that staff are continually required to balance a number of tensions and as such staff require a secure base from which to explore the service-users' unique recovery process through the medium of the therapeutic relationship (see figure below for illustration).

I have listed the five main themes and their sub-categories below explaining a little about each.

Theme1: Balancing tensions

A strong theme that emerged was the continual negotiation of a number of tensions that originate throughout an individual's recovery process. These tensions are created through a range of sources, which may not always be experienced as supportive of recovery. Thus, this entailed repeatedly weighing containment for security reasons versus emotional containment for therapeutic reasons. Different phases through the recovery process can pose different challenges, which may require a return to the secure base or the therapeutic relationship to restore the recovery progress.

Negotiating service factors

There are a number of factors within the secure environment and practice guidelines or directives from the NHS and/or the ministry of justice, particularly in the current context, that can leave practitioners feeling forced to restrict recovery goals such as self-responsibility, empowerment and choice. Staff actively work with risk management but did also see some benefit of having an external party, removed from the possible emotional involvement clinicians may develop with service-users, to monitor risk management.

Making links with the external world

There are a number of external stressors to contend with when supporting service-users accessing the community or taking up roles within the community, such as education. This requires active attempts to improve links with the community and overcome a number of obstacles. These obstacles entailed factors such as the stigma of society's negative views of service-users and a lack of resources or community support. The impact of these negative external forces could lead practitioners to fulfil quite protective roles for the service-users.

Managing emotional impact of work

The work with service-users while balancing all these tensions could at times create a sense of fear and vulnerability within staff. A self-awareness of these emotions and sufficient supportive structures are required to monitor how staff negotiate restricting/enforcing while retaining open and collaborative relationships with service-users. These feelings could be amplified through the process of handing power over to service users with the fears of litigation or experience of feeling 'stripped' of their professional expertise created by the imposition of directives seemingly opposing recovery principles.

Theme2: Secure Base

In order to promote and support recovery in this context a solid foundation is required for both staff and service-users. The base itself constitutes contextual factors, support structures, and a recovery narrative and ethos.

Creating a homely environment

There are numerous recovery benefits afforded by creating a warm unit environment that “modelled normal life” in which service-users can contribute to the running of the unit, through for example food shopping and preparation. Furthermore, staff and service-users could engage in shared activities such as eating dinner together and being able to engage in ‘normal’ conversations. The small size of the unit was repeatedly raised as a positive contribution to this homely environment, facilitated by a number of supportive structures such as weekly house meetings and daily debriefs. It was also important to facilitate peer support among the women and developing healthy relationships with family members outside of the unit.

Recovery Culture and Allegiance

Signing up to a recovery ethos, that was embedded in the culture and language of the unit and was supported by management, makes the promotion and maintenance of a recovery approach possible.

Working as a team

In order to work well as a team there is the need to manage the emotional impact of the work, be that personally or through the process of team splitting. This is supported through the availability of regular training, supervision, reflective space, staff monitoring self and each other, and drawing on the expertise of the different professionals within the team.

Theme3: Therapeutic relationship

Trusting and collaborative therapeutic relationships with service-users provide the medium through which recovery can be actualised. In maintaining these therapeutic relationships, sometimes it is necessary to explicitly work with the roles that service-users may consciously or unconsciously put them in at times.

Way of being

Staff way of being was defined as a human approach to care that often resonated with individual’s own personal way of relating and with the core principles of their profession. This entails openness, honesty, being non-judgemental, and being empathic all of which were considered important in developing, and sustaining, therapeutic relationships that offer a sense of constancy.

Treating Service-user as a whole person

A person-centred approach to service-users as unique individuals beyond diagnosis, offence status, or gender is vital in developing therapeutic relationships. Understanding service-users presentations, particularly women’s presentations, in light of their past experiences, which often entailed disrupted, traumatic and/or abusive relationships elevates the need to attend to the establishment of secure relationships in order to support recovery. It is considered important to not impose or assume an understanding of service-users difficulties but rather should aim to explore this with service-users.

Being alert

In sustaining healthy relationships, there is a need to be alert to not only service-users nonverbal communications but also to staff’s own, and the team’s ability to remain bounded and consistent in approach to service-users. An ability supported by the secure foundation of supervision and sufficient staff to client ratio.

Theme4: Initiating recovery

It appeared that a number of personal and interpersonal factors influenced when or how an individual’s unique recovery journey would begin.

Service-user inputting into their recovery

In order to facilitate the recovery process staff spoke of needing to give the responsibility and choice to the service-users and jointly focus on what was important to service-users rather than impose staff's goals. Service-users were positioned as experts in their care yet staff also empathised that this could inadvertently pressurise service-users to recover, evoking feelings of fear.

Timing

Timing referred not only to establishing when might be the most appropriate time to begin the process but also to referred to recognition of the length, and sometimes arduous nature, of the recovery process for service-users. There was also an awareness of the enforced length of time that staff and service-users had together. There appeared an ambivalence regarding the therapeutic value of an extensive time together versus a sometimes unnecessarily extended time due to perceived risks or resource constraints.

There was a differentiation between the recovery process and the end goal of recovery; and how the secure environment, acute mental illness, and service-users stage of recovery influenced both of these aspects. The stage of recovery was affected by service-users motivation and desire for change that was shaped by their fears of what progress might entail.

Working alongside

The initiation of the recovery process was personal to each service-user and requires staff to patiently work at the service-users pace, to gradually enable and empower them to take the lead in their own recovery. Staff appeared to value the uniqueness of each individual highlighting the need to tailor their approach and recovery plan to each service-user in a client-centred manner. This approach could at times evoke feelings of unease in staff by being led by service-users as they fought not to rush the process or felt at times they may want to slow the process for the service-users own safety. To work with this required an honesty and communicating with service-users.

Theme5: Nurturing recovery

A number tasks, goals, and strategies foster the recovery process within the unit and towards an aspired end-goal of a successful move-on.

Future Orientation

The participants described experiencing a number of conflicts as the constraints of service-factors and external influences became increasingly more pronounced as future orientated move-on goals are negotiated. Service-users belief in the possibility of recovery relies on staff's ability to remain positive and hopeful, and thus being able to instil hope in the service-users. A strong focus on the future and getting a person to the position of being able to move on is considered important.

Doing it safely

Practitioners work collaboratively with service-users in helping them recovery safely. This may at time require staff to impose safe limitations or being aware of different activities and grading them or breaking them into small achievable tasks. Possible problems along the way are anticipated and clearly planned for. The planning is done jointly with service-users, and shared as a multi-disciplinary team.

Enabling and Empowering

A strong theme that emerged was the active task in enabling and empowering service-users through their recovery. This entailed focusing on their strengths and in developing their skills and confidence through education, enhancing their understanding and having viable opportunities in the environment.

Breaking Institutionalisation

A large aspect of nurturing recovery entails offering the service-user choice and practitioners offering support through the process but also knowing when it is helpful to step back and allow the service-user to take responsibility and positive risks. There is a clear recognition that the offering of choice may be overwhelming for service-users initially, as a result of their personal histories and history of contact with services that may not have facilitated independence in the same manner.

Please see the figure below which attempts to illustrate the process within and across the main themes:

Thank you for taking the time to read my results!

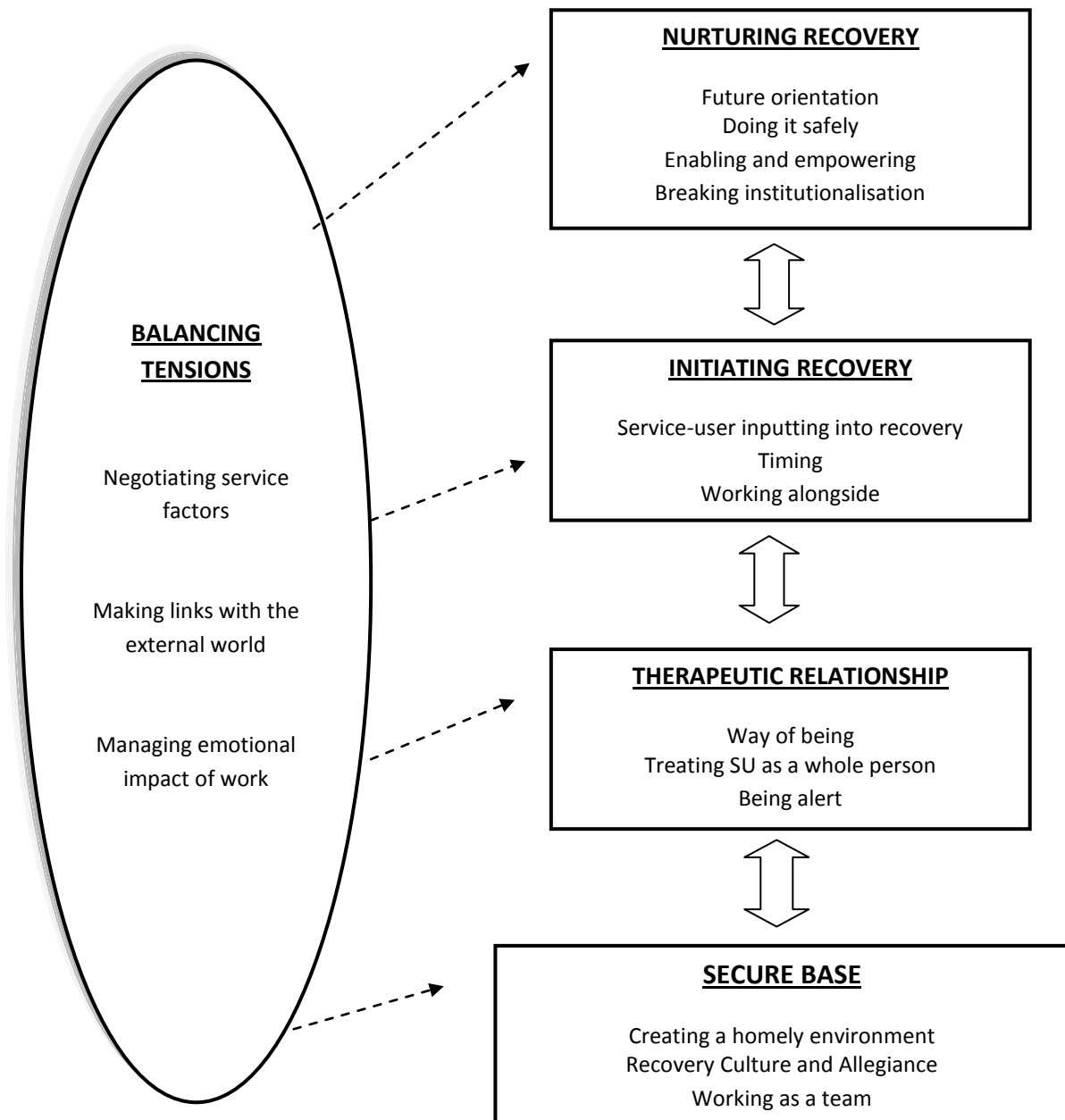


Figure 1: Preliminary model of applying a recovery approach with women with a diagnosis of personality disorder in secure care

Appendix 15: End of study notification to Ethics

Miss H Millar
 Trainee Clinical Psychologist
 Department of Applied Psychology
 Canterbury Christ Church University
 Broomhill Road
 Tunbridge Wells
 Kent
 TN3 0TG

Research Ethics Committee

10/07/2011

Dear [REDACTED], Chair of Research Ethics Committee

Study Title: **Exploring 'recovery' with staff working with women diagnosed with a personality disorder in secure settings.**

REC reference number: *****

I write now with the summary of my findings for the abovementioned study. Please also find enclosed the end of study notification form.

The study commenced on 8 February 2011 and finished on 1 July 2011. The aim of the study was to develop a preliminary model of how staff conceptualise and apply recovery approaches with women with a diagnosis of personality disorder in secure care. Multidisciplinary staff working in [REDACTED], a local women's medium secure unit, were recruited for the study. Semi-structured interviews were conducted with 11 staff members, majority of whom were either nursing staff (including nursing assistants and students) or allied health professionals (including psychology and occupational therapy).

Grounded theory was used to analyse the data and a preliminary model was developed. Five main categories were constructed from the data with several subcategories, as shown in the table below.

Categories	Balancing Tensions	Secure Base	Therapeutic relationship	Initiating recovery	Nurturing recovery
Subcategories	<ul style="list-style-type: none"> • Negotiating service factors • Making links with the external world • Managing emotional impact of work 	<ul style="list-style-type: none"> • Creating a homely environment • Recovery culture and allegiance • Working as a team 	<ul style="list-style-type: none"> • Way of being • Treating service-user as a whole person • Being alert 	<ul style="list-style-type: none"> • Service-user inputting into care • Timing • Working alongside 	<ul style="list-style-type: none"> • Future orientation • Doing it safely • Enabling and empowering • Breaking institutionalisation

The results suggest that staff are continually required to balance a number of tensions in this environment as they explore the service-users' unique recovery process. Staff are actively required to make links with the community to support social inclusion amidst constraints of limited resources, service directives, risk-management priorities, and the stigma this population group encounter in wider society. Staff are repeatedly weighing containment for security reasons versus emotional containment for therapeutic reasons. Different phases through the recovery process can pose challenges, which may require a return to the 'secure base', or the therapeutic relationship, to restore the recovery progress.

Staff are in a better position to deal with inherent conflicts and tensions when they have a 'secure base' from which to develop therapeutic relationships with service-users and jointly explore their recovery. Staff signing up to a recovery ethos, that is embedded in the culture and language of the unit, and supported by management, makes the promotion and maintenance of a recovery approach possible. A conducive 'homely' environment supported recovery by enabling the establishment of collaborative relationships between staff and service-users; and allowed service-users to fulfil valuable roles within the unit that allowed for skill, and self-confidence, development. This environment was facilitated by the small unit size.

The support that staff require to advance recovery extended beyond the emotional impact from working directly with service-users, at an individual or a team level, but also regarding the sense of vulnerability and uncertainty that arises through balancing the number of inherent tensions, including being led by service-users through the recovery process. Context specific training regarding recovery was identified as necessary to enable a team to work well together towards a shared vision. Services can support the establishment of the 'secure base' through the provision of regular supervision and reflective spaces that enable staff to maintain an open, positive approach to the work.

Concordant with the wider recovery literature, the findings suggest that it is possible to promote recovery principles of hope, identity formation, opportunities for choice and self-responsibility, and empowerment through the establishment of trusting, collaborative relationships. Staff's personal perspective could foster these relationships, if they included an honest, non-judgemental, respectful approach to service-users as unique individuals beyond their offence or diagnosis status.

This theoretical account of how staff understand recovery in this context can serve as a base for necessary secure-service-specific recovery training; and for further research in other units, and with service-users.

With regards to dissemination, preliminary findings were sent to participants for feedback and this will be followed by letters, with a summary of the final results, to participants and the service. Furthermore, I am intending to have the results published in a peer-reviewed journal, namely the [REDACTED], following submission of the report to Canterbury Christ Church University as part of the doctorate in clinical psychology.

Yours sincerely

Hayleigh Millar
Trainee Clinical Psychologist

cc. [REDACTED], R&D facilitator, [REDACTED]
[REDACTED], Research Governance Manager, [REDACTED] NHS Research Consortium

DECLARATION OF THE END OF A STUDY

(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee that gave a favourable opinion of the research ("the main REC") within 90 days of the conclusion of the study or within 15 days of early termination. For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	Miss Hayleigh Millar
Address:	Department of Applied Psychology Canterbury Christ Church University Broomhill Road Tunbridge Wells Kent TN3 0TG
Telephone:	01892515152
Email:	[REDACTED]
Fax:	01892507660

2. Details of study

Full title of study:	Exploring 'recovery' with staff working with women diagnosed with a personality disorder in secure settings.
Research sponsor:	Canterbury Christ Church University Paul Camic Dept of Applied Psychology, Broomhill Road Tunbridge Wells Tn3 0TG UNITED KINGDOM
Name of main REC:	[REDACTED]
Main REC reference number:	10/H1111/40

3. Study duration

Date study commenced:	08/02/2011
Date study ended:	01/07/2011
Did this study terminate prematurely?	Yes / No <i>If yes please complete sections 4, 5 & 6, if no please go direct to section 7.</i>

4. Circumstances of early termination

What is the justification for this early termination?	
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5. Temporary halt

Is this a temporary halt to the study?	Yes / No
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	<i>e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.</i>

6. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	
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7. Final report on the research

Is a summary of the final report on the research enclosed with this form?	Yes / No <i>If no, please forward within 12 months of the end of the study.</i>
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8. Declaration

Signature of Chief Investigator:	
Print name:	Hayleigh Millar
Date of submission:	11/07/2011