STAFF EXPERIENCES OF USING THE RECOVERY MODEL IN FORENSIC SETTINGS WITH PATIENTS WITH A DIAGNOSIS OF PERSONALITY DISORDER

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ABSTRACT

'Recovery' has been described as a central plank within mental health policy, however, research has tended to focus on service users' experiences and there is limited research looking at how staff experience recovery ideas. There are added challenges and barriers when 'recovery' ideas are applied to forensic settings for staff to contend with. The validity and reliability of personality disorder diagnoses has long been disputed and critiqued but remains a highly prevalent diagnosis within the forensic service user population. Research suggests that staff may treat individuals with a personality disorder diagnosis more negatively that other groups of service users, which has implications for their recovery. This research aimed to explore how staff in forensic services experienced using recovery ideas with individuals given a diagnosis of personality disorder.

Semi structured interviews were conducted with eight staff members from a variety of disciplines who worked in forensic settings. A Thematic Analysis of the data was conducted and four themes were identified; 'Recovery; Is this what we do?', 'Connections; being part of something', 'Identity; where do we go from here?' and 'Working with systems; where the power lies'. A Thematic map was generated from the data.

The findings are discussed in relation to existing literature. Clinical implications are made including recognising the huge emotional impact this work has on staff and better supporting them, and the need to address systemic barriers that result in service users with a personality disorder diagnosis becoming 'stuck' in the system. Recommendations for future research are highlighted

1. INTRODUCTION

1.1 Overview

The following introduction provides a historical overview and context for 'recovery' in mental health, followed by an outline of how recovery ideas have been applied to forensic services considering the barriers inherent to this setting. A critical overview of the development of personality disorder diagnoses is presented, before considering these diagnoses within forensic services and the implications for applying recovery ideas to this population. Finally, the rationale and research questions for the current study are provided.

1.2 The History Of 'Recovery'

The rise of recovery ideas in mental health was borne out of complex historical, social, cultural, and political influences. After the second world war, Europe, the US, and other anglophone countries underwent a process of psychiatric reform and deinstitutionalisation (Crossley, 2005), where the purpose and success of psychiatric hospitals were slowly challenged. The reported explanations for the radically reduced legitimacy of mental institutions were varied and contested (Goodwin, 1993). Numerous factors, including the advent of psychotropic drugs, economic factors and fiscal burden, the development of welfare policies, and counterculture movements including the anti-war, women's rights and equal rights movement were considered significant and contributory (Vasconcelos & Desviat, 2017).

The term 'anti-psychiatry' was reportedly first coined in 1967 by David Cooper (Crossley, 2006). This counterculture movement challenged the fundamental claims and practices of psychiatry. The movement provoked a variety of different reactions (both within and outside those critical of psychiatry) and started a profound chain reaction of effects that continues to be felt to this day (Crossley,2006). The movement stated that psychiatry was a mechanism of social control and psychiatric diagnoses were rejected as harmful labels. The anti-psychiatry movement helped open up space for psychiatric politics, and the first key 'patients' social movement organization (SMO) *The Mental Patients*

Union' emerged. The anti-psychiatry movement coalesced with the growth of consumerism in the welfare state (Mclean, 2003). These movements were in part a response to centuries of violence and bloodshed, whereby people with 'mental illness' were stoned, burned at the stake, locked in cages, and subjected to inhumane conditions where they could be insulin shocked, hydro shocked or lobotomised (Davidson, Rakfeldt, & Strauss, 2010). In the late 80's the patient movement was transformed into a survivor advocacy movement and gave rise to SMO's such as *'Survivors speak out'* and *'United Kingdom Advocacy Network'*. These led on to the current generation of survivor activists and new protest cultureinclude 'Mad pride'.

Deegan (1988) states that the origins of 'recovery' in the psychiatric survivor movement had empowerment and resistance to the dominance of psychiatry as its main goals. These early accounts by individual pioneers gave challenging and sometimes oppositional voices to what recovery looks like from the inside. The movement highlighted the profound discrimination faced by people who have been 'psychiatrised' and affirmed that individuals that have been diagnosed are not objects to be acted upon (Deegan, 1997). Patient-controlled alternatives outside of mainstream services such as 'peer support' were championed.

The large-scale deinstitutionalisation in the second half of the 20th century was met with the development of 'community-based care' and psychiatric rehabilitation as an alternative. This led to new conceptualisations of how services for people with severe mental health problems should be organised and delivered. This laid the foundation for the gradual emergence of the 'recovery vision' in the 1990s (Anthony, 1993). The development of community-based care arose within a neoliberal political context, which has been criticised for subjecting services to efficiency models, targets, and dogmatically evidencing their effectiveness (Howell & Voronka, 2012) and aimed to treat involuntarily individuals in the least restrictive way in the community. However, the involuntary and sometimes coercive nature of CTOs is inherently oppositional against the recovery approachas they undermine an individual's sense of autonomy and choice (Osborn & Stein, 2017). O'Hagan (2012) has argued that CTOs represent the single biggest barrier to recovery in the community and are discriminatory and a violation of human rights.

1.3. The Recovery Model

The term 'recovery' has been used extensively in mental health literature since the survivor movement and has been conceptualised as a model, a set of principles, a framework, movement, and an orientation (Llewellyn-Beardsley et al., 2019). Definitions and conceptualisations of 'recovery' vary expansively, though they broadly state that the recovery model aims to alter the power and priorities between service users and professionals. Davidson and Roe (2007) state that although there is increasing global commitment to recovery as *the* expectation for people with mental health problems, there is little consensus as to what recovery actually means.

Bonney and Stickley's (2008) review paper looked at over 170 British studies of recovery and found that the manner in which recovery was defined and delivered between stakeholder groups differed widely. Davidson and Roe (2007) argue that recovery has become a conflation of two ideas "recovery from" which is equated to clinical recovery from the symptoms of mental distress, and "recovery in" which is a person focused definition. How services and policymakers define and understand recovery has huge implications for service delivery, professionals, and service users.

'Clinical recovery' emerged from professional led research and is underpinned by key operationalised principles (Slade, 2009). Slade et al. (2014) report that clinical recovery is viewed as an outcome or a state and is generally dichotomous in nature. Secondly, it is objectively observable in clinical practice and rated by an expert clinician, not the patient. Finally, within 'clinical recovery' the definition of recovery does not vary across individuals. Clinical recovery is, therefore, intrinsically linked to the medical model of mental health, with mental health clinicians often more accustomed to the clinical definition of recovery compared to the concept of 'personal recovery' (Anthony, 1993).

Opinions in the consumer/service user/survivor literature about recovery are wide-ranging and cannot be uniformly characterised (Slade, 2009). Personal recovery is thought to be a subjective experience and an individual's understanding of their own recovery may change over time (Slade et al., 2014).

Anthony's (1993) seminal paper setting out personal recovery is often quoted in literature and defines recovery as:

"A deeply personal process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing way of life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness"
(Anthony, 1993, pp. 527).

Anthony (1993) explored how the principles outlined by Deegan (1988) could be utilised by mental health services, giving rise to what has been popularised and known as 'the recovery model'. Personal recovery is defined as a process that takes place within and by the individual, whereby the individual is the central actor of the process (Topor et al., 2011). Within personal recovery, it is assumed that individuals hold the knowledge and are best placed to lead their recovery journey, with individuals having the primary understanding, not professionals. The goal of the recovery process is not to become 'normal'. Whilst clinical recovery and personal recovery may be intertwined at points, for some individuals, clinical recovery may be part of their journey, whereas for others the idea is unhelpful or toxic (Slade, 2009).

There have been many autobiographical accounts that describe the personal journeys that individuals have made to recover and take control of their lives (Deegan, 1988; Leete, 1989). These narratives and subsequent research have made crucial contributions to our understandings of mental health problems and recovery. Until relatively recently, individuals with mental health problems were described exclusively in terms of their deficits, disabilities, and symptoms (Andreasen, 1984). These individuals were construed as victims and helpless, it was not deemed necessary by professionals to give time or space to the persons'thoughts, experiences, or points of view. Within this context, it was paramount to emphasise and give voice to the individual and personal nature of recovery.

Leamy et al. (2011) conducted a systematic review and narrative synthesis of 97 conceptualisations of 'recovery'. They developed 3 overlapping models with

service user involvement in the final modelling. 'Characteristics of the recovery journey', 'recovery processes', and 'recovery stages' were devised. The conceptual framework for 'recovery processes', identified the key themes of connectedness, hope, identity, meaning, empowerment, and spirituality giving the acronym CHIME. The CHIME model has been used in various studies as a framework to assess recovery in individuals.

The authors are clear that CHIME is not conclusive, and that recovery will involve a different combination of processes for different individuals. Criticism of the CHIME model has highlighted the often-non-linear nature of recovery and an omission of the difficulties inherent in the recovery journey (Stuart, Tansey, & Quayle, 2017). 'Hope' is highlighted by the CHIME study and is widely recognised as an essential factor in recovery (Niebieszczanski, Dent, & McGowan, 2016). Hope has consistently been identified as a "common factor" contributing to change and gains in psychotherapy, with practitioner hope influencing therapeutic outcome over and above service user hope (Coppock et al., 2010).

The personal recovery definition reinforces the idea that recovery is a unique andindividual process, which suggests that there cannot be a singular, unified recovery model for services. This is an exceptionally challenging notion within theconcepts of clinical guidelines, care pathways, and evidence-based practice, and Slade (2009) further argues that it is fundamentally incompatible with the primary goals of the mental health system. It requires an inordinate level of transformation to incorporate truly 'recovery' based services and "human systems do not transform easily" (Slade et al., 2014).

How recovery ideas are received by non-white individuals is a further consideration for services and policymakers. In Leamy's (2011) study ethnic minority groups reported recovering from racial discrimination, stigma, violence, and not just from mental health problems. Whilst BME individuals do not represent a single or homogenous group, Leamy (2011) suggests that the groupmay share some similar experiences especially in terms of oppression and discrimination. The study suggested that recovery for BME individuals could involve a greater emphasis on spirituality and stigma and new themes of culturespecific factors and collectivist notions of recovery may be necessary. This highlights the need to consider intersectionality within recovery services

and policies.

1.3. Recovery Model in Policy and Guidance

Recovery has been described as 'the central plank' of mental health policy (Pilgrim, 2008). Over the last 25 years, government mental health policies have increasingly cited the promotion of recovery as a key outcome including the 'National service framework for mental health' (Department of Health, 1999), 'The journey to recovery: The government's vision for mental healthcare' (Department of Health, 2001), 'New Horizons: Towards a shared vision for mental health' (Department of Health, 2011), and 'No Health without mental health' (HM Government, 2011).

'New Horizons set out the expectation that services to treat and care for people with mental health problems will be accessible to all who need them, based on the best available evidence and focused on recovery, as defined in discussion with the service user' (Department of Health, 2011, p. 7). '…ensuring that people with mental health problems are able to plan their own route to recovery, supported by professional staff who: help them identify and chief the outcomes that matter to them… put them, and their families, and carers, at the centre of their care' (Department of Health, 2011, p. 6). Off the back of these policies, there was the introduction of 'support, time, recovery workers (Department of Health, 2009) and recovery teams, as well as recovery interventions such as the 'Recovery Star', Wellness and Recovery Action Plan (WRAP) and Recovery Colleges (MacKeith, 2011).

1.4. Effectiveness of the Recovery Model

Field (2016) states that the recovery model has been part of the mental health landscape for over forty years yet has failed to improve outcomes for service users. Although given the lack of clarity of concept and frequent misapplications,has the recovery model been part of the landscape for over forty years, or as Davidson et al. (2005) state, 'it is just old wine in a new bottle'? It is therefore difficult to accurately determine the impact of the recovery model and evaluate its effectiveness in terms of reach and in shaping policy.

Epidemiological research has long demonstrated that recovery from mental

health problems is possible and common. For example, Harding et al. (1987) reported recovery rates of over two thirds in their sample and Harrison, Hooper, and Craig (2001) reported that over half of their sample which included individuals deemed to have severe and enduring presentations had favourable outcomes. However, epidemiological research has been criticised for focusing on clinical recovery and the remission of clinical symptoms and is therefore not looking at individual and personal recovery (Corlett & Miles, 2010).

1.5. Criticisms of the 'Recovery Model'

The concept of recovery has been criticised for being ambiguous and vague (Beresford, 2015) with the assumptions and implications from different positions creating discrepancies. As previously mentioned, the concept is difficult to definedue to its individual, personal, and fluid nature. Lilleleht (2002) reiterates the catch 22 position whereby patients are trained to be independent but must remain compliant and dependent on a new body of psychiatric knowledge in order to be defined as 'recovered'.

Services often explicitly state they are recovery-focused and adopt a recovery philosophy without altering practice (Wallace et al., 2016). Recovery-oriented care cannot just be added to existing services. There are numerous barriers to change, including differing philosophies, regulatory processes, clinical traditions and policies, and staff resistance to change, which all need to be considered and managed (Shanks et al., 2013). Park et al. (2014) state that there is a lack of research exploring the relationship between recovery and risk in the context of mental health services, with an overemphasis on risk impacting the promotion of service user's social inclusion and recovery.

Whilst the idea of recovery had its roots in the survivor movement over time the concept has become more mainstream. It is argued that the concept has changed from an organised framework for psychiatric survivors to avert the medical system through alternative means (peer support and knowledge), they are now harnessed to incorporate psychiatric survivors into medical systems (Howell & Voronka, 2012). Winship (2016) argues that recovery has journeyed from a movement to method to a set of maxims with monitoring and measurement (Winship, 2016).

Concepts of personal recovery used by services often fail to recognise the socialand structural barriers that can influence, facilitate, or impede recovery, with Morrow and Weisser (2013) calling for an intersectional social justice analysis of recovery. They argue this analysis needs to account for how power is distributed within the mental health system and the interlocking forms of oppression throughwhich it operates. On the other hand, the rise of recovery is generally seen as a uniformly positive thing by its proponents, Winship (2016) suggests that there is a necessary demarcation between clients who are 'amenable to recovery' and those who are 'harder to engage'. This suggests that recovery begins with the presupposition of client cooperation and in terms of the recovery college approach to be a willing student in the process of education.

One research participant in Morrow and Weisser's (2013) research stated that "Recovery is not a concept that I really relate to because I don't think that I'm recovering from my life experiences, I'm incorporating them. I'm not surviving, I'mbecoming" (World Café Participant, Morrow and Weisser, 2013, pp. 27). Recovery narratives are popular amongst mental health services and have been used to instruct professionals about their role in the recovery process, model recovery, promote the narrator's own recovery, reinforce the idea that recovery ispossible or demonstrate the efficacy of a particular intervention (Jackson & Greenley, 2001). The institutional uses of recovery narratives, however, raises serious ethical questions. Costa et al. (2012) argue that there is an appropriation and overreliance of the psychiatric "personal story", and that personal stories have been harnessed for institutions' own interests and used and abused as sought-after commodities.

Costa et al. (2012) argue that personal narratives on recovery have been used toharness support, gain funding, or press coverage for the systems that [survivors]recognise as part of the problem. Survivors' stories have suddenly been discovered as useful by dominant structures and incorporated into neoliberalist mental health agendas in order to support and sustain their validity.

Recovery is often described as an individual process (Anthony, 1993; Deegan, 1988). Although recovery takes place within the individual it also takes place by the individual within a relational, social, and political context, which is often

deemphasised and backgrounded in the context of a neoliberal framework (Toporet al., 2011).

Korsbek (2016) argues for greater consideration for the context of recovery as it unfolds within human relationships (friends, family, and professionals), and how these relationships can impede or facilitate recovery. Research has indicated theimportance of reciprocal professional relationships in a person's recovery.

Focusing on the individual can obscure the political and social links between distress and structural injustice (Harper & Speed, 2012). Within definitions of personal recovery (e.g., Anthony, 1993) the emphasis is on the individual to change. If the individual can change their attitudes, goals, feelings, values, they will affect change in their life (Harper & Speed, 2012). Recovery definitions often speak of acceptance, which can be taken to mean that the individual must accepttheir mental illness and therefore accept they have an illness and endorse the medical model (Harper & Speed, 2012).

As previously mentioned, prior to the survivor movement the voices of individualsexperiencing mental health problems was missing and silenced from literature, it was therefore imperative to emphasise the individual aspect of recovery and give voice to this at that time to counter the totalising, pathologising discourse of medicine. Therefore, a better balance between the personal and political aspects of recovery is necessitated.

Whilst it appears that in recent years there has been a paradigm shift in UK mental health policies and in practice in terms of lessening the focus on illness led models in favour of recovery-based approaches, Harper and Speed (2012) argue that the recovery model as it is commonly used in policy and practice is, in fact, a deficit and illness led model. Harper and Speed (2012) argue that the recovery model does not remove the notion of deficits, instead simply reframing deficits as'strengths' and is therefore reliant on deficit-based models. By failing to move away from deficit-based models, there is a restricted repertoire available to problematise these inadequacies.

Slade et al. (2014) state that the recovery approach has been used to justify

cuts to services. Over the last 50 years, there has been a progressive shift in managing the care of severe mental health problems from that of collective social responsibility to private, individual responsibility (Hunt & Resnick, 2015). The introduction of personal social care and personal health budgets seems to shift greater power to the individual, however, absolves some responsibility of the state (Perkins & Slade, 2012).

1.6. <u>Recovery in Forensic Settings</u>

Secure settings are potentially one of the most difficult places to consider applying recovery principles (Drennan & Wooldridge, 2014) and adopting the approach has proved contentious to some (Clarke et al., 2016). In recent years, however, 'Secure recovery' has become more widespread and become a more integral part of government policy (Simpson & Penney, 2018). The Mental Health Secure Care Programme (REF) was established in 2016 to deliver the recommendations in the 'Five Year Forward View for Mental Health' with a "stronger focus on recovery". NHS England 'Strategic direction for health services in the justice system: 2016 – 2020' identified 7 prioritised areas including 'Supporting rehabilitation and the move to a pathway of recovery'.

NHS England (2013) report that commissioners in England currently purchase approximately 7719 inpatient beds in secure mental health services. Of these approximately 795 beds are in high secure services (commissioned for England and Wales), approximately 3192 beds are in medium security services and approximately 3732 beds are in low-security services. As aforementioned, since the 1950s there has been an increasing tendency towards community-based care, with the numbers of general psychiatric inpatient beds decreasing. During this same period, however, beds in forensic psychiatric services have increased (Hare et al., 2018).

The provision of secure care is very expensive. In the UK, MSU's cost around £175,000 per patient per year, costing £1.2 billion per year. This is 1% of the entire NHS and 10% of the mental health budget. This is compared to the cost per year of an individual in prison of approximately £25,000 (Ministry of Justice, 2016). However, the rising demand from prisons, especially for adult secure care means that in 2016 the annual audits reported circa 100 prisoners were waiting for transfer to an adult secure hospital. In terms of the Mental Health Act

(1983), the CQC report monitoring use of the Mental Health Act in 2015-16 showed detention rates have continued to rise in recent years and 2014-15 saw the highest ever year-on-year rise (10%) to 58,400 detentions (CQC, 2016).

There exists a large body of research that suggests that black and minority ethnicgroups (BAME) have more compulsory admissions under the Mental Health Act, longer hospital admissions and more readmissions (Barnett et al., 2019). The "Count me in" census for England and Wales showed higher rates of admission for mental illness and more adverse pathways to care for some black and minority ethnic groups. However, rates vary among different BAME groups. Several explanations for the disparities have been put forward including racism and service discrimination, with increased prevalence of certain mental health conditions among particular populations reflecting social inequalities.

Barnett et al. (2019) conducted a systematic review and meta-analysis looking at compulsory detention in the UK. They found that black Caribbean men were significantly more likely to be detained compared to white British men. They found that the most common explanations for the increased risk of detainment in BAME populations included increased prevalence of psychosis, increased perceived risk of violence, increased police contact, absence of or mistrust of general practitioners, and ethnic disadvantages. Fernando (2017) states that racism in systems of control is epitomised in forensic psychiatry.

Since the millennium there have been major reconfigurations to secure forensic services, with a reduction in high-security services and the expansion of low and medium-security services, with an increased emphasis on specialisation and gender-specific initiatives (Sahota et al., 2010). Long, Fulton, and Hollin (2008) report that the inadequacy of inpatient facilities for women and the potential for iatrogenic harm is well documented and evidenced. There are several important differences in the characteristics, security needs, and treatment needs of women in secure services (Sahota et al., 2010). It appears that women are more likely to be suffering from psychological distress and less prone to criminality compared to their male counterparts. When women are convicted of an offence, they are seven times more likely to be given psychiatric disposal compared to men, with women accounting for just 6% of the prison population. Women are also more likely to have histories of sexual and physical

abuse as children and domestic abuse as teenagers and adults (Davenport, 2004).

When comparing the characteristics of men and women admitted to MSU's, menare more likely to have been admitted from prison whereas women from generalpsychiatric services, women are therefore more likely to be admitted on a civil section with no index offence (Maden, Snapinakis, & Lewis, 2006). Women are more likely than men to have committed arson, but less likely to have committedviolent crimes or have a history of drug misuse (Coid, Hickey, & Yang, 2007).

Around 12% of all medium secure patients nationally are women, which is four times as many as in 1995 (Hassell & Bartlett, 2001). Women also stand to lose their liberty for four times longer than women peers in prison and for longer than their male peers (Aitken & Logan, 2004). The above reported significant gender differences in those admitted to secure services suggest that the delivery of services should look very different for men and women which is now being recognised and implemented (Sahota et al., 2010).

1.7. Obstacles to Implementing Recovery in Forensic Settings

Forensic mental health patients (FMHP) are doubly stigmatised with both mentalhealth problems and prolonged or repeated exposure to the criminal justice system (Drennan & Wooldridge, 2014), facing huge restrictions on their autonomy and liberty. FMHP are a heterogeneous group of individuals because they are often defined by other's people's reactions to them and rarely have a single diagnosis (Adshead and Dorkins, 2011). Adshead and Dorkins further suggest that their explicitly antisocial lifestyles and behaviours may be all that forensic mental health patients have in common.

Adshead and Dorkins (2011b, pp. 184) stated that one of their patients reported that "You can be an ex-bus driver, but you can't be an ex-murderer". The stigma of a 'spoiled identity' (Goffman, 1986), which has been 'spoiled' by a mental illness label and past offences, make it difficult for service users to feel like they can 'recover' their past identities. Adshead (2018) further suggests that the challenge of forensic services may be to help service users transform their

identity and help them with their own narrative of recovery.

Adopting a recovery-oriented approach poses a number of challenges for forensic settings as the values and ethos of secure settings can directly differ from the recovery approach. For example, having the patient lead the process of recovery is a deeply challenging notion for forensic services, when services have to additionally consider future risk and public protection (Dorkins and Adshead, 2011). Drennan and Aldred (2012) introduced the idea of 'offender recovery' as an additional and fundamental task for forensic service users. The 'offender recovery' concept suggests an offender needs to come to terms with the offences they have committed, appreciate the need to change, including potential personal factors that contributed to their offending, accept a degree of future risk of reoffending and accept the range of consequences of their offending behaviour (Drennan and Aldred, 2012). Although succinctly summarised into a few sentences, the enormity of a proposed 'offender recovery' task cannot be underestimated.

Mezey and Eastman (2009) speak of the 'inherent contradiction' between supporting patient choice and autonomy, whilst pursuing involuntary detention for their previous antisocial choices, whilst Dorkins et al. (2008) have suggested that the limitations of secure settings necessitate 'optimal choice' as an alternative for forensic mental health patients, which feels like a far cry away from Anthony's (1993) vision. Although Anthony asserts that "professionals do not hold the key to recovery, consumers do", in forensic settings professionals quite literally hold the keys, and this serves as a constant visual reminder of the power imbalance inherent in this setting.

The values and identities of some forensic service users are particularly challenging as the recovery model implies that service users wish to be citizens (Slade, 2009), however, some service users appear to choose a value set that is different from professionals and the social communities they have come from.

There remains ongoing debate about how cruel, violent, or unusual attitudes and beliefs should be understood, although Sadler (2008) suggests that this debate isbeyond a simple dichotomy of 'mad' or 'bad', whereby the 'mad' are

afforded therapeutic intervention and the 'bad' are not.

Dorkins and Adshead, (2011) further suggest that many communities do not wanttheir offenders back, resulting in forensic service users facing social exclusion as the community response to violence and trauma. Developing a sense of self that is separate from an 'offender identity' is deemed crucial for recovery, however, thehopelessness of this task can be too overwhelming for some individuals (Simpson & Penney, 2018).

The importance of the therapeutic relationship and true partnership by working withmental health professionals is seen as central for recovery (Leamy et al., 2011). This, however, assumes that service users are capable (at that time) of forming trusting therapeutic relationships. For some service users whose early experiences of care was cruel, abusive, and dominating, this can be extremely difficult if not impossible given the constraints of the system. Mann and Matias (2014) also suggest that 're-enactments' of abusive relationships may hinder recovery promoting relationships. Ruszczynski (2010) found that an attacking/neglectful relationship to care often develops in relationships with staff, these could be seen as re-enactments of severe disruptions in childhood attachments which were characterised by loss, neglect, and abuse.

A key recovery task may be to develop a 'secure base' and be able to experience emotional safety in a relationship. Given staff pressures, reduced patient contact time, and the high turnover rate of staff this task becomes even more difficult. Service users damaged ways of relating and staff's lack of capacity may lead to staff being drawn into re-enactments and undermine the containment they could provide (Aiyegbusi, 2009). This suggests that the link between an individual's service engagement and attachment style may mirror their earlier childhood experiences of caregivers. Aiyegbusi, (2004) suggest that insecure attachments are particularly prominent in the forensic population, particularly those characterised by a difficulty in understanding the emotional needs of others and oneself and as a dismissive stance towards relationships, this may be particularly true in times of crisis.

Poor 'mentalisation' (the continuing process of keeping the mind in mind;

Fonagy & Adshead, 2012) and a reduced capacity to communicate psychological needs in non-violent ways may affect the extent to which a forensic service can be patient-led (Mann & Matias, 2014). The explicitly stated needs of the patient may be different or conflicted with the underlying psychological needs. Mann and Mathias (2014) share the clinical example of when a patient wants to be discharged from hospital but communicates indirectly through a positive drugs test (for example) their underlying anxiety and need for containment. Forensic settings can come to represent a secure base and therefore leaving it may threaten a persons' emotional security. To help overcome the difficulties arising from insecure attachments and poor mentalisation as an obstacle to recovery, Mann and Mathias underline the importance of staff reflective practise groups to look at countertransference and re-enactments as well as programmes designed to improve patient's mentalisation skills.

'Systemic obstacles' such as system anxiety, power differences, and social exclusion impact applying 'recovery' to forensic settings. Menzies' (1960) seminalpsychodynamic analysis of healthcare organisations suggests that organisations hold a substantial amount of anxiety and that staff employ a variety of defences to cope with this. In forensic services staff experience the countertransference of anxiety from patients as well as risk management concerning sexual and violent offending, suggesting that organisational anxiety is likely to be even higher in forensic services.

Mann and Mathis (2014) also suggest that a reliance on the medical model and diagnosis function to reduce system anxiety could be achieved by simplifying peoples' experiences and providing a level of certainty. If the system were to adopt a truly individualised approach this could be seen as threatening and increase anxiety and uncertainty, which could be too overwhelming for the system.

Risk assessment and risk management is seen as a fundamental part of working with forensic mental health patients. The literature appears uncertain as to whether this can be conducted in a recovery-oriented fashion (Simpson & Penney, 2018), or whether this is just tokenistic or plain unrealistic. 'Risk obstacles' such as procedural security and restrictive practice, risk

assessments, and transparency of practice create tension, increase unequal power dynamics, and can undermine collaborative ways of working.

Due to the complexities of recovery in forensic settings, especially anxiety-inducing issues such as the risk of harm to others, Kaliski and De Clercq (2012) argue that there is often an unacknowledged difficulty with different members of the multidisciplinary team subscribing to different paradigms, creating tensions, and divergent risk management plans, which create additional barriers to an individual's recovery.

1.8. Forensic Service User and Staff Perspectives

Two recent reviews have looked at the key principles of recovery as expressed by forensic mental health service users (Clarke et al., 2016; Shepherd et al., 2016) and revealed broadly similar themes.

Clarke et al. (2016) conducted a systematic review and narrative synthesis, and ofthe 11 papers considered the authors found considerable overlap across the studies. They organised themes into 6 superordinate themes with 'connectedness' and 'sense of self' particularly prevalent. The other themes were'coming to terms with the past', 'freedom', 'hope', and 'health and intervention'.

Clark et al. (2016) suggest that these themes are broadly consistent with the recovery processes identified in general mental health recovery research (e.g., Leamy et al., 2011), with the difference being in the barriers to these aspects of recovery. 'Freedom' and 'Coming to terms with the past' are considered to be more unique to the forensic population the latter, they suggest, incorporates the vulnerable nature of this client group who have often experienced histories of abuse and also need to come to terms with their own harmful behaviour. The importance of interpersonal connectedness for facilitating recovery is repeatedly shown as a strong and recurring theme in the literature (Clarke et al., 2016; Dorkins & Adshead, 2011; Simpson & Penney, 2018).

The therapeutic relationship is consistently reported as central and catalytic to the recovery process and as one of the strongest predictors of service user

satisfaction in forensic mental health settings (Bressington et al., 2011). However, forensic mental health patients have a reputation of being 'difficult to engage' and forming a therapeutic relationship can take considerable time and skill from staff (Davidson et al., 2005).

Corlett and Miles (2010) evaluated the implementation of the recovery philosophy in a secure forensic setting using the DREEM tool by interviewing staff and patients. Whilst two-thirds of staff believed that there were delivering recovery-oriented care, a third did not think that they were giving recovery-oriented care to patients. The research did not look at what kind of care the staff thought they were giving instead. Staff consistently rated the implementation of the elements of recovery higher than patients, suggesting that staff may overestimate how recovery-oriented a service is, or that the evaluation did not capture what elements of recovery are most meaningful to patients.

1.9. Evidence Base for Secure Recovery in Forensic Settings

Similar to critics of the recovery model in general psychiatric settings, critics of recovery in forensic settings have argued that in clinical settings little has changed beyond the rebranding of rehabilitation services, which were based on the medical mode and deficit and pathology (Beresford, Nettle, & Perring, 2010). Jackson-Blott et al. (2019) interviewed service users and mental health staff and reported that the bio-medical model remains dominant in clinical practice.

While there is some evidence that a recovery-oriented approach is associated with better mental health and social outcomes for patients in general mental health services (Warner, 2010), there is less evidence of the applicability of the recovery approach in specialist settings such as forensic services (Mann, Matias, & Allen 2014). How 'recovery' should be measured is also complex and multifaceted. Recovery literature refers to the concept as both a process and an outcome, therefore deciding what dimensions of recovery should be measured and at what points in time they should be measured has caused some confusion (Hunt & Resnick, 2015).

1.10. History of the Personality Disorder Diagnosis in the DSM

Many historians of psychiatry consider Phillipe Pinel (1745-1826) the first author to include personality disorder in psychiatric nosology, when he introduced a category termed "manie sans délire" (mania without delusion; Crocp, 2013). During the late 19th and early 20th century, several elaborate systems of normal and abnormal personalities emerged. Emil Kraeplin (1856-1926) introduced personality types into modern psychiatric classification, under the term 'psychopathic personalities' (Crocq, 2013).

The modern era of personality disorders is considered to have begun with the creation of The Diagnostic Statistical Manual of Mental Disorders (DSM) in 1952 by the American Psychiatric Association. The DSM aimed to provide mental health professions with a uniform common language for diagnosing individuals with mental health problems in the United States. The DSM is focused on in this study as opposed to the UK equivalent manual (International Classification of Diseases (ICD)) as the DSM has powerful worldwide influence as it is the preferred system for funding and publishing research (Johnstone, 2014). The ICD, however, is based upon the same principles as the DSM and closely mirrors it in terms of classification labels.

Since the DSM's inception, there have been five subsequent editions published. Earlier editions were based on narrative psychodynamic descriptions of psychiatric disorders (Kress et al., 2014). In the first edition of the DSM, personality disorders had brief descriptions, with the second edition only dedicating 3 pages for the description of 10 named personality disorders (American Psychiatric Association, 1968). Neither the first nor second editions of the DSM were supported by any research evidence or epidemiology, or theory of potential underlying causes to personality disorders (Trestham, 2014). Early editions were criticised for these questionable foundations, a lack of discrete diagnostic criteria, lack of consensus and poor reliability issues (Blashfield et al., 2014).

The DSM-III (American Psychiatric Association, 1980) introduced the multiaxial system and categorical symptom-based diagnosis. The edition aimed to radically improve reliability, with researchers conducting empirical studies for each diagnosis before including it in the manual (Spitzer & Fleiss, 1974). The

DSM III's creation was meant to represent a major advance in the scientific aspiration within psychiatry, as well as indicate emergent professional consensus. The manual proposed to eliminate the disarray that had characterised psychiatric diagnosis (Bayer, 1985). The DSM III represented a paradigm shift away from psychoanalytically informed ideas towards atheoretical neo-Kraepelin ideas that aimed to bring psychiatry back to its medical roots (Blashfield et al., 2014).

The multi-axial system assessed five areas (Axis I: affective presentation, Axis II:personality or intellect, Axis III: medical disorder, Axis IV: psychosocial stressors, Axis V: function). Axis II purported to contain pervasive, fixed, and inflexible psychological issues such as personality disorders and mental retardation (now intellectual disability) that shaped responses to more acute Axis I disorders (APA,1980). The separation of 'personality disorders' from Axis I clinical disorders was decided upon using expert consensus (Widiger et al., 2005). The separation was based on scarce empirical evidence and therefore lacked validity (Bateman, 2015). Critics of the separation argued that there were extensive comorbidity across axis I and II disorders (Skodol, 2002) and that evidence of shared environmental and genetic risk factors existed, suggesting common aetiological factors (Orstavik et al., 2007). Furthermore, clinicians reported a lack of qualitative difference between Axis I and II disorders and a lack of evidence to reflect the apparent enduring nature of personality disorders compared to other clinical disorders (Krueger, 2005). The impact of separating personality disorders from clinical disorders has arguably had profound implications for the way that services and provisions were structured and how clinicians conceptualised individuals with a personality disorder diagnosis.

Nominal changes were made to the categorical diagnostic nature of personality disorder diagnoses in DSM IV (APA, 1994) and DSM IV-TR (APA, 2000) and by the time DSM V (APA, 2013) was being written it became clear that there remained no clear consensus to underlying neuropathology or optimum approach to personality disorder diagnosis (Trisman, 2014). A proposed change back to a dimensional classification system was argued (APA, 2013), or a hybrid with both categorical and dimension elements was suggested but this was ultimately rejected. The multiaxial system was, however, removed and personality disorders were categorised alongside other clinical disorders.

Currently, the DSM V (APA, 2013) defines a personality disorder as: "An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." Ten diagnosable personality disorders are classified (Table 1).

Table 1: DSM V (APA, 2013) Personality Disorder Classifications

DSM V (APA, 2013) Personality Disorder Classifications
Avoidant personality disorder
Schizoid personality disorder
Schizotypal personality disorder
Paranoid personality disorder
Histrionic personality disorder
Narcissistic personality disorder
Obsessive-compulsive personality disorder
Dependent personality disorder
Borderline personality disorder
Anti-social personality disorder

1.11. Controversy Within the Diagnostic System

Proponents of a diagnostic system state that despite its limitations the DSM system remains useful (Dailey et al., 2014). Diagnosis reduces a lot of complex client information into a manageable form, and through categorising symptoms into disorders, diagnosis provides a means to select appropriate evidence-based treatments (Kress et al., 2014). Furthermore, some individuals find having a diagnosis reduces shame and self-blame (Kress et al., 2005). The diagnostic system also lends itself to the development of research including prevention, early intervention, and effective treatment measures (APA, 2013).

Controversy and critique of clinical diagnosis are growing (Johnstone, 2014). Surrounding the publication of the DSM V position statements from the British Psychological Society raised their concerns about the 'continuous medicalisation of natural and normal responses" (DCP, 2013), The Division of Clinical Psychology state that:

'The DCP is of the view that it is timely and appropriate to affirm publicly that thecurrent classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations and there is thus a need for a paradigm shift in classification in relationto these diagnoses, towards one which is no longer based on a "disease" model.'

Concerns about diagnosis and the DSM have been raised by the chairs of both DSM III and DSM IV committee chairs (Robert Spitzer and Professor Allen Francis) who have publicly voiced their concerns. Professor Allen stating that the DSM 5 "will radically and recklessly expand the boundaries of psychiatry" and "there is no reason to believe the DSM V is safe or scientifically sound (Francis, 2014).

Major classification systems are based almost exclusively on observable behaviours (signs) and self-reported feelings and thoughts (symptoms) rather than on their underlying causal mechanisms (Clark, Nuzum, & Ro, 2018). Clark et al. (2017) suggest four core issues surround the categorisation of mental disorders: aetiology, comorbidity, thresholds, and categories/dimensions. Furthermore, what is and is not classified as a mental disorder is often steeped inpolitical agenda and historical influences (Kress et al., 2014).

1.12. <u>Personality Disorder: Current Context</u>

Since the 2000's there has been an increased public and political awareness of issues to do with 'personality disorder'. Following the conviction of Michael Stone for the murders of Lynn and Megan Russel in 1999, serious failings of the mental health system and criminal justice system were exposed. This resulted in improved funding and changes to the law. The Dangerous and Severe Personality Disorder programme (Department of Health, 1999) was initiated as was the creation of policy guidance; *Personality Disorder: No longer a diagnosis of exclusion* (National Institute of Mental Health in England, 2003)*,* as well as, *Breaking the cycle of rejection: The personality disorder capabilities framework* (National Institute for Mental Health in England, 2003b)*.* Following criticism and negative evaluation of the DSPD programme, this was superseded by the Offender Personality Disorder Pathway in 2011 (Department of Health and The Ministry of Justice, 2011). The above changes have fundamentally changed the

culture of mental health services towards 'personality disorder'. Dale et al. (2017) estimate that since the publication of *Personality Disorder: No longer a diagnosis of exclusion (NIMHE, 2003),* there are 5 times the number of dedicated 'personality disorder' services.

Epidemiological studies have suggested that between 5 and 10% of the adult population of the UK meets the criteria for a personality disorder diagnosis (Samuels et al., 2002). Personality disorder diagnoses are associated with early mortality, for women their life can be shortened by 19 years and men 18 years. (Personality Disorders Commission, 2018). Individuals with a diagnosis of personality disorder will often use a considerable range of statutory services and find little benefit from them (Benefield & Haigh, 2020).

Van Asselt et al. (2008) states that the individual and societal cost of 'personality disorder' is difficult to calculate but is likely to be enormous. The CQC (2016) examined hospital episode statistics and estimated the yearly cost attributable to 'likely personality disorder' as £10 million. Benefield and Haigh (2020) state that this is likely to be a huge underestimation.

As a psychiatric diagnosis, personality disorder diagnoses are perhaps one of themost controversial and highly critiqued. It is therefore argued that the current categorical DSM PD system is broken with little basis in data and unworkable in clinical practice (Krueger et al., 2014).

1.13. Critique of 'Personality Disorder' as a Diagnosis

The current DSM V categorical model of personality disorder has severe shortcomings. In research protocols, classification systems (DSM V and ICD 11)demonstrated sufficient reliability, however, in clinical practice, complex coding has proved largely untenable and has resulted in low interrater reliability (Johnstone, 2014).

Validity refers to whether or not a construct refers to a distinct concept (Paris, 2015). Clark, Nuzum, and Ro's (2018) review states that two major nosological flaws exist for the PD construct. They suggest that comorbidity (the co-occurrence of two putatively distinct disorders) is highly problematic.

Individuals with a diagnosis of one personality disorder often meet the criteria for at least one other personality disorder, with estimates in inpatient samples being as high as 4.6 (Skodol, 1988), yet theoretically, these patients only have one personality, which suggests invalid categorical structure. Furthermore, over a third of individuals donot meet the criteria for one specific personality disorder diagnosis and are given the diagnosis of personality disorder not otherwise specified suggestive of poor nosological coverage. Further conceptual issues include arbitrary diagnostic thresholds, huge heterogeneity within diagnostic categories, and poor operationalisation of the general criteria (Skodol, 2012). A substantial number of individuals also attract diagnoses such as depression and anxiety or have substance misuse diagnoses. Furthermore, within research the confound of 'comorbidity' is often ignored, questioning the validity of findings and research which seldom looks at the third of individuals who have the label "personality disorder, not otherwise specified".

The notion of personality has been apparent in the West for many centuries and has been considered a Eurocentric, individualistic concept (Cromby, Harper, & Reavey, 2013). The lack of consensus surrounding 'normal personality' is also highly problematic, as Livesley (2017) states, not only ideally, but logically, any nosological deliberation towards separating disordered personality must be founded upon a theoretical understanding of what 'normal' personality is. Burr (2003) suggests that from a social constructionist perspective, there is no objective evidence that demonstrates the existence of personality. Burr challenges the concept of personality itself and suggests that any personal qualities we do display are a function of the particular cultural, historical, and relational positions we find ourselves in. Yang, Coid, & Tyrer's (2010) epidemiological study found that only 23% of a standard population had no personality 'pathology' as measured by the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II). The implication of this study is that over three-quarters of the population exhibited interpersonal problems. Yang et al. (2010) concluded that 'personality pathology' is normal and everywhere.

The diagnosis of personality disorder is stigmatising, morally loaded, and value-laden (Cromby, Harper, and Reavey, 2013) and implies personal responsibility

on the individual for their distress (Bourne, 2011). Sibbald (2020) suggests that personality disorder can be seen as a dustbin diagnosis, the diagnosis given when you don't recover. Being given a diagnosis of personality disorder can directly impact the level and quality of care the individual receives. A well-known article by Lewis and Appleby (1988) titled 'Personality disorder: the patients psychiatrists dislike' called for the end of the diagnosis of 'PD'. The authors interviewed staff in general mental health settings and found that patients given a previous diagnosis of personality disorder were seen as more difficult and less deserving of care compared with control subjects. The individuals with a personality disorder diagnosis were regarded as manipulative, attention-seeking, annoying, and in control of suicidal urges. The authors concluded that personality disorder appears to be an enduring pejorative judgement rather than a clinical diagnosis, and they proposed that the concept be abandoned.

Following Lewis and Appleby's findings, numerous studies (mainly focusing on the diagnosis of borderline personality disorder) have reported similar findings. For example, Cleary, Siegfried, and Walter (2002) found staff reported communicating and interacting with this client group more difficult compared to other client groups. Markham (2013) study of psychiatric nurses found increased negative attitudes, less empathy, and less optimism compared to patients diagnosed with psychosis or depression. Deans and Meocevic (2006) found that over a third of the staff they interviewed disagreed or strongly disagreed that they knew how to look after patients with a diagnosis of BPD.

A study conducted by Bodner et al. (2015) looked at reported cognitive and emotional attitudes towards patients with borderline personality disorder including 'difficulty to treat' and 'empathy' in different staff groups. They found that nurses and psychiatrists exhibited more negative cognitive attitudes and less empathy compared to psychologists and social workers. Freestone et al. (2015) conducted a systematic review looking at the impact on staff of working with "personality disordered offenders". They identified 27 studies and highlighted that negative attitudes, staff burnout, stress, and damaging countertransference experiences were reported by staff when working with "personality disordered offenders". Two studies in their review reported a positive impact on staff: job satisfaction and excitement.

1.14. Interventions for Personality Disorder

One of the arguments for psychiatric diagnosis is that it indicates what treatment is evidence-based for that diagnosis. However, the evidence base for the treatment of personality disorders is insufficient (Bateman & Fonagy, 2016). The majority of research evidence is focused on borderline personality disorder, with a dearth of research on other diagnoses. Completed research is often limited by small sample sizes, heterogeneous sample populations, and differences in assessment criteria and measurement (Bateman & Fonagy, 2016).

Historically it was considered that personality disorder was incurable and untreatable (Paris, 2005). Long term studies, however, have reported that only about half of the individuals given personality disorder diagnoses retained these diagnoses over follow up periods ranging from 6 months to 15 years, in various populations (Skodol, 2007). However, it is still considered among some clinicians to be enduring and irretractable (Paris, 2005).

Benefield and Haigh (2020) suggest that up to one-third of individuals locked in rehabilitation wards have a primary diagnosis of personality disorder, however, these services are not specifically commissioned to offer evidence-based personality disorder interventions. They further suggest that a reduction of NHS inpatient beds has led to a polarisation of treatment options for individuals with a personality disorder diagnosis, with generic locked rehab units or limited community provision being the two options. Benefield and Haigh (2020) argue that treatment has become a 'one size fits all', while many of the people who need it most, do not fit at all.

Various types of psychological therapies for personality disorders have been developed, such as Dialectical Behavioural Therapy (DBT, Linehan, 1987) and Mentalization-Based Treatment (Bateman & Fonagy, 2004), however, no one modality of psychotherapy has been found to be more useful than the other (Bateman et al., 2015). Furthermore, the iatrogenic impact of individual psychotherapy has been highlighted for this population (Fonagy & Bateman, 2006). Ramsden (2020) suggests that what we know works for people with a personality disorder diagnosis is far more complex than individual treatment

approaches would suggest.

1.15. <u>Trauma-Informed Care</u>

The importance of providing 'trauma-informed care' in mental health services hasgrown in significance over the last few years (Sweeney et al., 2018). There is a current drive within secure services to work towards becoming 'trauma-informed',and it is rapidly becoming a central pillar of current forensic practice (Pilgrim, 2020).

Research has long recognised the high rates of trauma reported by individuals with a personality disorder diagnosis. Zanarini et al. (1998) reported that 91% of individuals in the study with a borderline personality disorder diagnosis reported having been abused, and 92% reported being neglected before the age of 18. The Adverse Childhood Experience (ACE) study was a three-year study (1995-1997) including over 17,000 individuals. The study reported the long-term effects of early trauma linked with significant health and social problems and early death (Felitti et al., 1998).

Traumatic events experienced early in life such as neglect, abuse, witnessing violence, and disrupted attachment can be devastating for an individual. These events can undermine or damage a person's sense of safety, self, as well as theability to regulate emotions and navigate relationships (Herman, 2015). To cope with their adverse experiences some individuals may use substances, self-harm, and/or use violence or aggression as a way to discharge or manage overwhelming emotions (Van Der Kolk, 2015).

The five values of trauma-informed care as suggested by Covington (2012) are listed in table 2. In becoming a 'trauma-informed' service, Covington suggests that organisations should aim to take into account an understanding of trauma in all aspects of service delivery and place a priority on the trauma survivors' safety, choice, and control. Staff should be provided training to recognise the potential forindividuals to be re-traumatised through their experiences in secure services, for example, through authoritarian relationships. Furthermore, the service should recognise the effect of working with trauma has on staff members and take steps to ameliorate these. Trauma-informed services would

further recognise the intersectionality of trauma, considering how an individual's experience of trauma intersects with other perceived identities such as gender, race, ability, age, class, and sexual orientation.

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Table 2: Values of Trauma-Informed Care (Covington, 2012)

Trauma-informed value	Description
Safety	Ensuring that individuals entering the service feel physically and emotionally safe through admission to discharge.
Trustworth iness	Individuals using the service know that the service and staff will ensure that expectations are clear and consistent and that appropriate boundaries (especially interpersonal ones) are maintained.
Choice	The preferences of the individuals seekingservices in routine practices and crisis situations will be prioritised.
Collaborati on	Input from individuals using the service will beconsidered in practices and decisions so that a collaborative relationship will be encouragedbetween those seeking services and service providers.
Empower ment	Services are developed and delivered to maximise service users' empowerment, recognising strengths, and building skills that will enable a successful transition from criminal justice settings to the community.

The introduction of 'trauma-informed services' has profound significance for

individuals with personality disorders in terms of their 'recovery'. There is

significant overlap between personal recovery ideas and the principles of trauma-informed care, but the author at the time of writing could not find any publications these ideas would fit together for individuals given a personality disorder diagnosis.

1.16. Recovery and Personality Disorder

Due to the difficulties inherent in the personality disorder literature, the concept ofpersonal recovery from personality disorder is arguably extremely problematic and research and clinical understanding are lacking. Shepherd et al. (2016) conducted a systematic review looking at qualitative studies of personal recovery in personality disorder and only found 3 studies. Of these, 2 exclusively looked at the diagnosis of borderline personality disorder. The review found that the themes showed some overlap with existing recovery frameworks such as Leamy et al. (2011), but also showed distinct and unique differences inherent in the difficulties faced by individuals given a personality disorder diagnosis. The themes were 'safety and containment as a prerequisite to recovery', 'social networks and personal autonomy in the recovery process', and 'identity construction as a process of change'. Therefore, blanketly applying research findings to individuals with a diagnosis of personality disorder may not be applicable and miss important differences that this group face.

The majority of individuals with a personality disorder diagnosis, do not commit offences, however, a significant minority do (Skett & Lewis, 2019). The prevalence of individuals with a personality disorder diagnosis in forensic systems (both criminal justice and health settings) is particularly high (Paris, 2015). Meltzer (2008) suggests that in the UK, up to 73% of prisoners awaiting sentencing, 64% of sentenced males, and 50% of female prisoners are estimated to meet the criteria for the diagnosis of personality disorder. The prevalence of personality disorder diagnosis among offender populations varies between the different diagnoses. The Office for National Statistics (ONS, 1998) found that of the prison population with a personality disorder diagnosis, 53% had an antisocial personality disorder diagnosis, 24.5% had a paranoid personality disorder diagnosis, 18.5% had a borderline personality disorder diagnosis, 10.5% had an avoidant personality disorder diagnosis, and 15-25% met the criteria for psychopathy. Within secure forensic inpatient settings, it is estimated that up to 70% of the patient population has received a diagnosis of personality disorder (Pilgrim, 2020). The majority of individuals with a personality disorder diagnosis have also received comorbid diagnoses of substance abuse and primary diagnosis of mental illness. Of patients admitted to high-security hospitals the average number of diagnoses is 3.6 (Coid, 1992).

1.17. Recovery and Personality Disorder in Forensic Settings

Personality disorder diagnoses are controversial and much critiqued, with a lack of theoretical consensus in academia. As previously mentioned, individuals attracting a personality disorder diagnosis are highly prevalent in forensic systems, yet research looking at what recovery means for this group of people is lacking (Shepherd et al., 2015). Patients in forensic units are an extremely heterogeneous group of individuals. They have experienced a vast range of difficulties and offending histories and attract a variety of diagnoses. Research tends to either homogenise the group as a whole or focus on recovery from psychosis (Shepherd et al., 2017). A recent systematic review found just 3 qualitative studies which looked at the experience of recovery from a personality disorder diagnosis (Shepherd et al., 2016), this is compared with 89 studies looking at recovery from a schizophrenia diagnosis (Andresen, Oades, & Caputi,2003).

Shepherds et al. (2017) interviewed 41 individuals across forensic inpatient and community settings with a personality disorder diagnosis and found that many participants detected uncertainty from clinical staff in terms of their understanding of the diagnosis of personality disorder which impacted participants feelings of hope for recovery. They identified 4 specific themes from the interview: 1. understanding early lived experience as informing sense of self, 2. developing emotional control, 3. diagnosis as linking understanding and hope for change, and 4. the role of mental health services. The narratives revealed the process of developing self-understanding within one's biographical history with an emerging greater control over their emotional experience. This process happened within the negotiations between the individuals, social networks and clinical staff which were complicated by 'offending against society'. For some participant's this process was disrupted by the varying attitudes of clinical staff which were at times perceived as being hostile in manner, which was an experience seen as particular to personality disorder.

1.18. <u>The Proposed Study</u>

'Recovery' within a mental health context is complex and subject to conceptual and empirical criticism but is widely accepted as the agreed standard. In recent years recovery ideas have been applied to the forensic population which has added additional barriers and layers of complexity. The diagnosis of personality disorder has long been disputed and critiqued but remains a highly prevalent diagnosis within the forensic population. Research suggests that staff may treat individuals with a personality disorder diagnosis more negatively than other groups of patients, which has implications for their recovery (Freestone et al, 2015).

Previous research has tended to focus on the experiences of the individuals whohave had the recovery ideas applied to them and not focused on the experiences of staff members. Although service users are in the best position to offer firsthand perspectives on recovery, clinicians are tasked with providing recovery-oriented services and interpreting and implementing recovery-orientated care.

The current research seeks to fill this gap in the literature. Individuals' who attract a personality disorder diagnosis were chosen as they are less researched in literature. This means that the proposed research would add a novel contribution to the research literature.

The proposed research is clinically relevant as recovery ideas are widely used in forensic settings (Drennan and Aldred, 2012) yet little is known about the experiences of those that are asked to apply its principles. Previous research hasalso indicated that staff treat patients with different diagnoses differently and it is unknown how this impacts staff experiences of recovery. This study aims to gather the experiences of staff members working in forensic settings using recovery ideas with patients who receive a diagnosis of personality disorder.

1.19. Research Questions

The proposed study is designed to explore the following research question:

"What are staff experiences of 'recovery' in forensic settings with patients given adiagnosis of personality disorder?"

The study will also explore:

"How does staff understanding of 'personality disorder' affect their use of the recovery ideas?"

"How does staff understanding of 'forensic patient/offender' impact their use of the recovery ideas?"

2. METHODOLOGY

The following methodology details the study's ontological and epistemological underpinning, rationale for qualitative method and the chosen approach (thematic analysis). It provides a description of the design used, as well as quality assurances and ethical considerations.

2.1. Epistemological and Ontological Position

Within different research paradigms there exist different ontological beliefs and epistemological positions (Madill, Jordan, & Shirley, 2000). It is therefore

important for researchers to consider and be explicit about the epistemological issues such as the theory, validity and scope of knowledge underpinning the research. Willig (2013) states that the assumptions reflected by the research question and the authors role in relationship to the research should be acknowledged before clarifying the method of data collection and the analytic process. By doing this, the quality of qualitative research can be improved (D Harper & Thompson, 2011). The epistemological stance informs which methodology will be most appropriate, shaping the nature of the research.

The research questions and rationale for this set out in the above introduction dictates that the study takes a Critical Realist position. Critical realism is ontologically realist in that it holds the assumptions that there is an external reality which can be identified and described by the researcher. It is epistemologically relativist in that it acknowledges different methods will produce different perspectives on reality. The study is intended to gather data that will tell us something about what is going on in the real world, but this will not be in a naive or unmediated manner (Willig, 2013).

A critical realist approach suggests that data needs to be interpreted to further our understanding of the underlying structure of the data, which will be mediated by social processes (Willig, 2012). Guba & Lincoln (1994) suggest that although reality exists it is only 'imperfectly apprehendable'. In the current study, interviews will be conducted with staff members. The data will reflect the staff members perspective, whilst the analysis will be an interpretation, constructed by the author based on a myriad of influences including my understanding, knowledge, and experiences. The knowledge, therefore, is constructed via the lens through which it is viewed.

Whilst a critical realist position will allow the study to identify potential underlying structures (for example forces or factors that influence participants experiences of recovery when working with individuals with a personality disorder diagnosis), there are also limitations in the kind of the knowledge the approach will allow the author to find. For example, the data will not focus on the subjective experience of staff members, it will not address the quality of feelings and perceptions that constitute the experience of using recovery ideas e.g., in a phenomenological

approach. The data will also not allow for knowledge to be gathered about the way that staff construct their experiences of recovery ideas through language, such as in social constructionist approaches.

2.2. The Appropriateness of Qualitative Methodology

Qualitative and quantitative research differ in their position on what is the central approach to gaining knowledge, with neither being a unitary entity in itself. Broadly speaking qualitative researchers aim to gain a rich understanding of the topic, possibly generating new theory. Qualitative research attempts to capture a sense of what lies within; it can attempt to explore, elaborate, and systematise the identified phenomena or provide an illuminative representation of an issue or problem (Bannister et al., 2011). Quantitative researchers are more concerned with the testing of theories or hypotheses and are more concerned with generalizability. Whilst qualitative studies can provide detailed in-depth examinations, they are less able to address questions concerning comparisons and causality or make predictions. Practical and personal considerations will also influence methodology choice.

The strengths of qualitative methodology suggest it is the most appropriate methodology for the research questions and epistemological position. Bannister et al (2002) describe qualitive research as representing part of a debate, not a fixed truth. They suggest that there will always be a 'gap' between the object of study and the way that we represent it. The process of interpretation by the researcher acts as a bridge to fill this gap.

The current research study is interested in gaining knowledge on the in-depth experiences of a specific subgroup of NHS staff members. The population of study (clinical staff in forensic settings) were considered relatively difficult to recruit, so it may not have been feasible to obtain the large quantities of data needed to complete a quantitative project with the resources and time scale available. A qualitative approach will enable better understanding of the potential

common experiences or differences between staff members, with less of a preconceived idea about what those experiences should be.

2.3. Choosing A Qualitative Method

Several qualitative methodologies were considered during the planning stage of the research, however, the advantages engendered by Thematic Analysis (Braun & Clark, 2006) were considered most appropriate for the study and are discussed below.

Grounded theory (GT; Glaser & Strauss, 1967) was initially considered. GT was developed to provide a method for new theories to emerge, specific to the context on which they were developed. The development of new theory does not rely on the variables, constructs, and categories from pre-existing theories. Considering the limited research reported in the above literature review the aim of the study was to be exploratory in nature. GT is more useful when there is the possibility of new theory development. It has also been suggested that GT is more applicable to sociological processes (Willig, 2013).

Phenomenological methods such as *Interpretative Phenomenological Analysis* (IPA, Smith, Flowers, & Osborn, 1997) are concerned with capturing a rich description of each participant's subjective experience, focusing on the quality and texture of the experience from their perspective (Willig, 2013). For the current study, although the research questions aim to produce knowledge about human experience, they are not specifically concerned with producing knowledge about the subjective experience of the participants and will not focus on their thoughts, feelings, and perceptions. Instead, the research questions demand an understanding of what may give rise to these experiences, for example the contextual factors such as the psychological, relational, systemic, and political factors that influence staff members experiences in forensic settings.

Discourse Analysis addresses how participants use discursive resources and its effects. The approach focuses on the way in which language is used to construct people's experiences, and the function that this serves to them and the wider influences (Potter, 2004). In this study, whilst the language that participants use

is considered important, the content of participants experiences is the main focus

of the study, therefore, it was considered that Discourse Analysis was not an appropriate method.

Thematic Analysis (TA; Braun & Clark, 2006) is a method for recognising and organising patterns in content and meaning in qualitative research, as such, it implicitly underpins most other methods of qualitative data analysis (C Willig, 2001). It has been argued that TA strives to be a more transparent and systematic form of qualitative method (Joffe, 2012). TA was favoured for the present study because of it's theoretical flexibility and accessibility for the novice researcher (Nowell et al, 2017). Furthermore, it enables the researcher to interpret the person's experience and the context in which these experiences arise (Braun and Clark, 2006). TA is focused on the patterns of meaning across data sets, rather than participants' individual experiences', which enables the analysis to support generalisations about the participants "reality". From the critical realist position, TA, "acknowledges the ways in which individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, whilst retaining focus on the material and other limits of reality" (Priya,2015, p.211). Braun and Clark (2006) also suggest that TA is useful method when the area being investigated is under researched, or the views of participants are not known. TA, therefore, fits well with the aims of the present study and the research questions.

2.4. Thematic Analysis

TA is widely used in psychological research for identifying, analysing, and reporting patterns (themes) within data (Braun & Clark, 2006). Thematic analysis is a flexible method that can encompass different epistemological positions as it is not wed to any pre-existing theoretical framework (Braun & Clarke, 2006). It is only relatively recently that TA has been recognised as a method in its own right (Braun & Cark, 2006; Joffe, 2012). However, there continues to exist some debate as to whether TA constitutes a qualitative method, in its own right, or whether it is more of a tool or skill used by other methodologies (Willig, 2013).

As TA is not tied to a particular theory or epistemological position, it is imperative that the researcher is clear what the theoretical status of the themes identified from the research represent. The research question and the researchers epistemological position dictate a critical realist TA, therefore, the themes in the current study are likely to represent the participants beliefs about and attitudes towards recovery when working with individuals with a diagnosis of PD. A critical realist TA will allow for both psychological and social interpretations across the data set (Braun & Clark, 2006). Themes will acknowledge the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of, reality (Willig, 1999).

When using TA as a method, there are a number of considerations for the researcher to reflect upon, which Braun and Clark (2006) discuss. Firstly, it is suggested that the researcher define what constitutes a 'theme' in the data set. Joffe (2012) defines a theme as a specific pattern of meaning found in the data set and Braun and Clark (2006) reiterate the importance of retaining flexibility and researcher judgement. In this study a theme will be considered by the researcher if it appeared to capture something important in relation to the research question. Meanings captured by a theme can be at the latent or semantic level and data can be analysed using an inductive or deductive approach. Joffe (2012) states that dual deductive/inductive and latent/manifest set of themes are used together in high-quality qualitative work. In the current study, the researcher will approach the data set with knowledge of previous findings and certain preconceived categories from previous theories, it will also draw on naturalistically occurring themes evident in the data and be open to new concepts that emerge (Joffe, 2012). Therefore, although themes will be identified that are strongly linked to the data (inductive approach), Bannister (2011) considers a purely inductive approach naïve as they suggest themes do not just emerge from the data, rather they are actively constructed by the researcher, informed by the author's experiences, beliefs and assumptions as well as previous literature (Taylor & Ussher, 2001). Braun and Clark (2006) provide a six-step process for conducting TA (table 3).

Table 3: Suggested Phases of Thematic Analysis Braun and Clark (2006)

Phases of Thematic Analysis	Description of the process
1: Familiarise yourself with the data	Immersion in the data. Active repeated reading, transcription of the data and noting initial ideas.
2: Generating initial codes	Systematically coding for interesting patterns in the data set and then collating them.
3: Searching for themes	Reviewing and the sorting the different codes into potential themes.
4: Reviewing themes	Refining candidate themes. Checking whether the data supports the themes. Collapsing and splitting themes and generating initial map of themes.
5: Defining and naming themes	Refining thematic map and identifying the story that each theme tells. Clearly define and name themes.
6: Producing the report	Select vivid examples of themes to provide sufficient evidence for a theme. Provide a compelling analytic narrative that makes an argument in relation to the research question.

2.5 Procedure

2.5.1. Research Setting

Participants were recruited from a London NHS Forensic Directorate incorporating low and medium security inpatient settings and a forensic

community team. The research team included myself (Chief investigator (CI) and interviewer) and clinical psychologist local collaborator (LC).

2.5.2. Identifying and Recruiting Participants

- Once ethical approval was granted by the NHS Health Research Authority (HRA) and Research and Development teams (R&D) in the NHS Trust, the CI contacted the LC to finalise the recruitment strategy.
- The CI attended a quarterly research meeting attended by psychologists working across the forensic directorate in the trust to advertise the study, explain the requirements for potential participants and hand out posters, information sheets and contact details for attendees to take back to their multidisciplinary teams. This was followed up with an email from the LC reiterating discussions and following up with interested participants.
- The LC sent emails containing a recruitment poster and information hospital wide advertising the research study.
- Potential participants registered their interest by either contacting the CI directly, or via the LC who forwarded their details to the CI with their permission.
- The CI sent interested participants the information sheet and consent sheet via email and then arranged an interview time and location to suit the participant.

2.6. Data Collection

2.6.1. Semi-structured Interviews

Semi structured interviewing is the most widely used data collection method in qualitative psychology (Willig, 2013). Interviews are concerned with the subjective meaning that participants accord to interview topics. Structured interview methods of data collection were deemed inappropriate as they would not to allow sufficient sensitivity to the complex issues under exploration. For example, inconsistent or contradictory views are not easily explored using

standardised questionnaires. Interviews termed 'unstructured' have been described as disingenuous as they fail to acknowledge the prior expectations or agenda that researchers have (Bannister et al., 2011). Semi-structured interviews were deemed the most appropriate as they are intended to provide some structure and guidance, making sure important topics were covered, whilst retaining sufficient flexibility to explore novel concepts and avenues opened by the interviewee, without leading the interviewee towards preconceived choices.

Willig (2013) recommends that interview schedules contain a small number of open-ended, non-leading questions, enabling the interviewer to gather an account that is not heavily shaped by the question, but allows detailed responses in relation to the research question.

The semi-structured interview consisted of 12 questions with a series of prompts and probes. The interview schedule was developed with the LC and incorporated the important areas identified from the literature review and were split into three sections: Questions asking more broadly about participants view of 'recovery' and what it meant to interviewees', questions surrounding forensic settings and some of the barriers experienced when working with services users and finally, questions surrounding personality disorder and participants experiences of this diagnosis in forensic settings and what impact this has on their understanding of recovery.

It is usual protocol to complete a pilot interview prior to conducting interviews for research. Due to delays in starting data collection and the short time frame in which to complete data collection, a pilot interview was not completed. Interview questions were reviewed by two local collaborators who were current staff members within forensic services, and who agreed that the questions were appropriate. A pilot interview would have been a useful process to have completed before data collection. However, due to the more flexible style of semi-structured interviews, questions were adapted to reflect participants style and language.

Bannister et al (2011) suggest that conducting interviews is full of 'tricky issues' fraught with uncertainties and complexities, which psychologists often defend against with personal and professional defences. One of these tricky issues is the consideration to the structural relationships and power inequalities that are set up by the research and the interview process. I considered my position as a representative of 'psychology' and what this meant when approaching staff from other multidisciplinary backgrounds, or individuals hoping to pursue a career in psychology. I may have been positioned as "expert" on this subject area, which could be intimidating for more junior staff, or, I may have been positioned as anti-psychiatry with certain biases or prejudices, which make have provoked defensive answers from psychiatry colleagues.

2.6.2. Inclusion and Exclusion Criteria

All clinical staff members employed on permanent or fixed term contracts by the trust will be eligible for selection, including students and trainees. External agency staff will be excluded as they may not have had the same training as permanent staff and may not fulfil the same job role.

2.6.3. Data Collection

Interviews last between 40 and 65 minutes. Before interview, the CI went through and discussed the participant information sheet (appendix 1) and gained informed consent (appendix 2). The interview then proceeded and was audio recorded. At the end of the interview, the participant was given a debrief sheet and given the opportunity to ask any questions. The CI emailed the participant the following day thanking them for their time, checking if any queries or questions had arisen since the interview. Potter & Hepburn, (2005) have criticised analysis from interview generated data for lacking attention to contextual features, such as interaction style and the stakes that participants have, instead taking data at face value. To address this, after each interview the I completed a journal entry (see appendix 6) noting salient things about the interview experience such as rapport, interaction style, impressions, feeling in the room and any thought or ideas that I had immediately after the interview.

2.6.4. Participants

Eight participants across various clinical disciplines were recruited to take part in the study (see table 4 below). Initially the plan had been to recruit ten-fifteen participants however due to the COVID-19 corona virus and subsequent 'lockdown', NHS clinical staff were under increasing time pressures and recruitment was halted at eight participants. Six participants completed their interviews face to face, with the final two being completed over the phone due to the 'lockdown' and the banning of non-essential travel and meetings.

Table 4: Participants

Participant no.	Discipline	Gender
1	Social Therapist	M
2	Clinical Psychologist	F
3	Psychiatrist	M
4	Clinical Psychologist	F
5	Social Therapist	F
6	Psychiatrist	M
7	Clinical Psychologist	F
8	Clinical Psychologist	F

2.6.5 Transcription of Interviews

Interviews were transcribed verbatim by the CI using a simple transcription method, as TA does not require a specific transcription convention (Braun & Clarke, 2006).

2.6 Ethical Considerations

2.6.1. Ethical Approval

Ethical approval for the study was sought and granted from the University of East London School of Psychology Research Ethics Sub-Committee, Health Research Authority (HRA) and permission granted from the local Research and Development (R&D), (appendix 3).

2.6.2. Informed Consent

Participants who registered their interest were emailed a copy of the information sheet and consent form and encouraged to ask any questions about the study during subsequent emails which arranged times and location of the interview. The researcher highlighted to potential participants that the interview would be audio recorded and that they could remove their data any time up until the start of data analysis which was expected to start in April 2020. At the start of the interview the researcher went through the information sheet and completed the consent sheet with participants. Deception was not used in this study and the researcher was transparent and clear about the research aims of the study.

2.6.3. Confidentiality

The limits of confidentiality were explained to participants at the time of registering an interest. Should interviewees have disclosed potentially abusive or neglectful practices, confidentiality would have been broken and shared with appropriate parties. This was explained to participants and did not occur during any of the interviews.

Communication with participants was completed through encrypted NHS email accounts. Audio recording equipment was stored in a locked drawer in the researcher's house. Audio recordings were started after introductions were completed to minimise personal information being recorded. The completed

recordings were transferred onto the researcher's personal password protected laptop at the earliest possibility and the audio file deleted from the audio recorder.

Participant interviews were transcribed using a participant number, and any identifiable information was removed during transcription. Only the researcher, supervisor and examiners have access to the transcripts. In accordance with General Data Protection Regulation transcripts will be retained securely for three years after completion of the study for the purposes of supporting dissemination or publication, and then permanently destroyed.

2.6.4. Wellbeing of Participants and Debrief

Due to the open-ended nature of questions, the interview may generate new knowledge for the participant (as well as the researcher). Participants may begin to think about their experiences in a new or different way, which could either be illuminating or distressing (Curtis & Curtis, 2011). After the interview, the researcher went through the debrief sheet and briefly reflected with the participant on the interview. The following day the researcher emailed the participant thanking them for their time and checked in on their well-being following the interview. The debrief sheet provided contact details of the researcher, supervisor, and relevant helping organisations they could contact if the interview had elicited anything distressing for them.

2.7 Evaluating the Quality of the Research

The quality of the research is presented in the critical review and was evaluated using the guiding principles outlined by. Nowell, Norris, White, and Moules, (2017) provide a framework for researchers to demonstrate the rigor and 'trustworthiness' throughout the process of conducting and analysing a thematic analysis. Nowell et al use the criterioivns of 'credibility', 'transferability', 'dependability', 'confirmability', 'reflexivity' and 'audit trails' to demonstrate 'trustworthiness'.

3. ANALYSIS

This chapter provides an account of themes generated from the data collected during interviews concerning participants experiences of using recovery ideas with individuals with a personality disorder diagnosis in forensic settings. The data was subject to Thematic Analysis using the steps described by Braun and Clark (2006) as detailed in the methodology.

3.1. Introduction to Themes

The analysis suggested that there were four distinct themes in the data; 'Recovery- Is this what we do?', 'Connections – being part of something', 'Identity-where do we go from here' and 'working with systems -where the power lies'. Each theme was made up of various codes which were subsequently described using quotes from across the data set.

Table 5: Themes

THEME	CODES
Recovery – **Is this what we do?**	Defining recovery
	Using recovery ideas
Connections – **being part of something.**	Hospital as home, staff as family
	Family involvement
	Hope
	Emotional impact
	Trauma

	Therapeutic relationship
Identity – **where do we go from here?**	Stigma
	Forensic identity
Working with systems – **where the power lies.**	The forensic system
	The medical system
	Power
	Risk

3.1.1. Recovery – Is This What We Do?

This theme captured how staff contemplated the meaning of recovery for themselves, their teams, service users and how it fitted for their client group. The theme also addresses whether recovery was experienced as relevant for patients with a diagnosis of personality disorder.

3.1.2. Connections – Being Part of Something

This theme recognizes the importance of connections for service users and staff members. Participants say that they find themselves positioned as part of service users' families, whilst working in systems that make connections problematic. This theme also explores the connections between service users and their families and their histories of trauma. Furthermore, the theme also highlights the emotional impact on staff of being part of the forensic system and being part of service users lives.

3.1.3. Identity – Where Do We Go From Here?

This theme describes how identities are constructed for service users through various labels such as "personality disorder" and "offender" and how broader influences such as stigma influence how the system and participants can see

service users. It also captures how participants seek to help service users forge new identities that are not constrained by systemic pressures.

3.1.4 Working with systems – Where The Power Lies

This theme captured participants and service users' interactions and difficulties with various systems, namely forensic mental health system, criminal justice system and the medical model. Systemic barriers impacted service user's recovery and determined how staff could utilize recovery ideas.

3.2 Theme 1: Recovery: Is This What We Do?

3.2.1. Defining Recovery

When reflecting on recovery as a concept, participants described it as 'ill defined', 'broad', 'vague', 'different views', 'umbrella term', 'massive topic'. Participants said that they weren't sure they knew what 'recovery' really meant or if they used it to inform their practice.

> PPT6: I mean, to be honest I'm not really even sure what, what does recoverymean? I'm not really even sure I really know what people mean by that
> PPT7: But then if we sit down and think, 'What do we really mean by recovery?'Yes. I'm trying to think what-, there's like-, what do we talk about now?
> PPT1: First of all, what does that even mean, 'fully recovered'? (624)

Despite ambivalence to the term, staff seemed to have developed their own understanding of recovery and what it meant to them: recovery was a broad term, highly individualized, was a process rather than a goal and needed to create meaning or align with service user values.

> PPT7: I think we all want people to, to kind of be able to feel satisfied in their life,and to be able to move on in a way that feels right for them (101)
> PPT8: it's about having an individual achieve the life and the level of functioningthat they're happy with, following, I suppose, an acute or an enduring episode of

mental illness. It's not necessarily about being symptom free or, having the life exactly they had before, but more so about, err, supporting them to achieve thethings that are meaningful to them and giving them, kind of, giving them more choice and having them feel more empowered.

Staff spoke about the importance of service users defining their own recovery and the negative implications of services or staff imposing their own recovery values on to Service users.

> PPT8: I think when using, kind of, a recovery model you have to be very carefulnot to impose your own ideas of what recovery is, err, and I think that can reallyhinder the therapeutic relationship (187).

> PPT5: And, you know, again, there's a, kind of, clash of our view of what is meaningful. Us, you know, we come into work at 9 o'clock, five days a week, working, it's obvious we're going to say, 'Look, doing work, or doing study, or something.' But there's a clash there because, you know, we're treating peoplewho have not had that with their lifestyle, so, and to a certain extent we want them to fit into our mould (268)

> PPT2: The word recovery-, it feels like we're the wrong people to decide. I mean,it's more, you know-, I, I don't-, I don't-, it doesn't really matter, in a way, what I think, if someone is content with the stage they've got to (160)

3.2.1.2 Offender recovery and personality disorder recovery

Staff spoke about it being unclear what service users were supposed to be recovering from. There were two aspects of recovery within forensic settings; recovery relating to being labelled an 'offender' and recovery linked to difficulties associated with a personality disorder diagnosis.

> PPT3: Um, and in forensics, what are we saying people are trying to recover from? I suppose that's the tension, it's that, kind of like, that, kind of, 'mad, bad'-, I'm using inverted commas there, that, um, when, where people with a forensic label sit, and that's where the real, kind of like, tension is. Um, because, um, theyfall under both of those quite frightening and threatening, um, deviant constructs.So, are we talking about recovery from badness? What the hell does that mean?

Um, I mean, and yes, you could say the same for mad, the construct of madness(233).

Offender recovery was linked to getting out of the system and risk reduction, although not necessarily having no support from mental health services. There was an emphasis on the persons responsibility to change criminal and violent behaviour to pro-social attitudes and behaviour. Offender recovery felt more prescribed and determined by the wider system. Staff described this aspect of recovery as creating 'tension'.

> PPT3: Um, implicitly so much of what we do is, is about, I suppose, supporting someone to live a more prosocial life. Um, and when we do, kind of like, violencerisk assessments where we do risk assessments, when we think about when someone's causing us a concern, so much of what we talk about that comes up is that stuff around, like, anti-social attitudes or, um, like, pro-violent attitudes, um, that kind of stuff. Um, which, kind of, feels really tricky when we're then talking about recovery, um, because recovery is a word that we think about in thecontext of health. (247)
> PPT5: So, certainly there's less emphasis on recovery, if you're talking about recovery for personality disordered offenders rather than just people with personality disorder, because for personality disordered offenders, they've got toget out of prison. Either they are there, or stay there, unless they prove themselves, you know, as safe enough to be discharged, where recovery is lessimportant, but risk reduction is more important. (334)

Staff commented that recovery when applied to service users with a personality disorder looked different. Whilst some staff thought that diagnosis had little impact on applying recovery ideas, some thought that recovery ideas fitted very poorly if at all with the construct of personality disorder.

> PPT1: Whereas others, they can, sort of, get rid of labels, but you can't [with personality disorder], but you can learn to live with them. So, I just feel like the way we make sense of it, the way we conceptualise different types of problems,can impact our understanding of recovery, or then what the actual recovery journey looks like, simply because we think of it differently and then engage in the process differently. (690)

PPT8: I think personality disorders, you know, to tell someone that you're recovering from your personality is quite a difficult message to give to someone(311)

PPT6: It just doesn't work; it's not fit for purpose for our guys (80)

PPT8: Err, but actually, I suppose when you're thinking about personality, that's abit trickier isn't it, because you're not-, it's not an event that's happened that they wanna, learn and grow from, they wanna, kind of, recover from. It's actually their entire life. It's been a build-up of events […] I don't think a model, maybe, works or has been developed enough to think about, or to include, maybe, that population (168).

Staff spoke about the importance of relational aspects and personal identity when applying recovery to personality disorder diagnosis.

PPT6: Um, so I guess if you can get it to the point where those difficulties with their identity or their self-concept or their relationships is not so problematic thatthey're hurting people or they're hurting themselves, um, then that would be recovery, maybe? (360)

PPT3: Um, he didn't change as a person, it was just, I suppose, his way of relating with himself and with others, and his way of articulating what he needed.Um, maybe that's the thing that had changed, and I suppose maybe that's wherethe, kind of like, relational recovery, I think is particularly relevant for someone with a personality disorder. (467)

When defining 'recovery' for individuals with a personality disorder diagnosis, participants noted that it did not mean returning to a previous life, or state of health.

PPT1: 'For a lot of them, recovery doesn't necessarily mean going back to something that was much better,' because they've never experienced it. (256) PPT8: Again, it depends on how you're thinking about recovery and if you're-, I think, you know, I, if you're looking at a life before and what it would mean for lifeafter and how you could get that back, then I think there's, there's barriers. Err, because their life before is their whole life (289)

Recovering from personality disorder was often contrasted with other diagnostic labels, especially psychosis. The relational and identity difficulties staff associated with personality disorder, were less amenable to recovery ideas compared to more discrete episodes of mental health problems experienced within other diagnostic labels.

> PPT1: Whereas others, they can, sort of, get rid of labels, but you can't, but you can learn to live with them. So, I just feel like the way we make sense of it, the way we conceptualise different types of problems, can impact our understandingof recovery, or then what the actual recovery journey looks like, simply because we think of it differently and then engage in the process differently. (690)

> PPT8: So, they are recovering from a set of difficult experiences, it's just, maybe,it's not-, I just don't think it applies in the same way as we think about it in terms of mental health (292)

3.2.2. Using Recovery Ideas

Participants at times said that they thought recovery wasn't relevant to the work they were doing with service users. As interviews progressed, however, they also reported using what they would identify as recovery ideas, even if they did not explicitly call the work recovery themselves.

> PPT6: No, not at all and we don't talk about recovery (55)

> PPT1: I wonder how, how often I've heard the word 'recovery' in the past, what,for a month now? Not very often (69).

For participants, recovery seemed to be something that was implicitly present and influenced their work, rather than articulated in an explicit or structured model.

> PPT1: because I only realise this now that we're talking about it, because we dotalk about recovery so much, and intuitively, it does feel as if we have a good understanding of what it is (825)

> PPT7: So, it's always kind of in the background, the word recovery.

> PPT8: err, I think it's, kind of, more of a working principle that are held in mind(43)

Using recovery ideas also depended on whether service users 'bought into' the recovery model. Participants reiterated that it was difficult to use if service users thought they had nothing to recover from.

> PPT7: Um, I mean, I think for some people they may feel that they're not-, they'vegot nothing to recover from, um (112)

> PPT3: For some of the guys, they may deny or not understand that there isanything to recover from. (492)

> PPT4: A lot of them don't see why they're there. They're, kind of, thinking, 'I haven't really done anything wrong, my index offence wasn't even that serious,why am I here?' (667)

3.2.3. Theme One Summary

Participants found defining recovery problematic, especially when applying it for services users with a diagnosis of personality disorder. Recovery from the offender label was more weighted towards risk reduction and 'getting out of the system'. Recovery from a personality disorder diagnosis was contentious, but might centre on service users improving their relationships with others. Staff felt recovery was different for the personality disorder population and the ideas did not fit as well. When staff spoke about using recovery ideas, they said that they used them in a more unstructured, implicit way.

3.3 Theme 2: Connections: Being Part of Something

3.3.1. Family Involvement

Connections to family or other people in the community was seen by participants as very important for service user's recovery. However, there was often felt to be a lack of family involvement, or it was felt that service users held unrealistic expectations about reconciliation. Family involvement was seen by staff as challenging for various reasons including because there had been offences

against the family or violence in the family. Feelings of rejection and abandonment transpired from difficult family relationships.

> PPT1: cause a lot of the men we work with; they do have family. Um, there are men whose families do not want to be in touch with them, who have decided thatthey don't want to be in, in their lives anymore, and you see-, you see the impactthat alone has on them, this sense of, you know, isolation, and abandonment and, 'Where is my home? You know, once I get out of here, where do I go? Whol-, who do I live with? I don't have a family. I don't have loved ones anymore.' Um, or uncertainties, you know, where individuals might have hurt family members, and they're somewhat hopeful but also anxious as to whether they willever be able to reconnect with them again. (776)

> PPT8: especially if one of the things about recovery is, is for them to feel, err,connected or to feel, err, part of the community and a part of-, it doesn't necessarily need to be family, but maybe their wider community. I think a lot more work can be done to help forensic patients work on those areas (265)

Reconnecting with family members was seen as a huge source of hope for service users. However, this hope may be unrealistic, and participants said it was difficult for them to hold this conflict for service users if they only saw potential positives.

> PPT7: Um, I think for some people that's where hope comes from, you know, tobe able to see their family and for their family to be involved (383)

> PPT6: 'The first thing that's going to happen when your family walk through that door is, they are going to run to you and they are going to embrace you and hugyou.' And obviously, that's really hopeful, really positive, great, but quite unrealistic, not going to happen. Um, and actually, you're going to have, realistically, they're going to have all sorts of emotions that come up when they meet family members that they haven't seen in a long time, or get back in touch with parents that they felt were neglectful or abusive. And it might be better to berealistic about that rather than purely hopeful, yes? (160)

3.3.2. Hospital as Home; Staff as Family

Participants said that considering the lack of connections service users experience in the community or with family, service users can come to place staff in the role of family members and see hospital as home. The hospital can represent safety and security and it can be scary and anxiety provoking for service users to leave hospital. Recovery could mean losing your 'family' and 'home' in the hospital, this could lead to service users consciously or unconsciously sabotaging discharge plans.

> PPT4: It can be quite scary for them to go back into the community and be on their own because sometimes they see us as, like, almost their parents in a way(306).

> PPT7: Sometimes the difficult task we have is about discharging people […] but then when it comes to discharge they find it too overwhelming and too much andsomething will happen that will slow down their progress or reverse their progress. Um, and I think that often happens when people don't have any senseof a family, they don't have-, their life feels quite empty in the community, they don't have any sense of-, people often talk to me about having roots. Um, so, I think that can make recovery really hard. And for a lot of people the hospital has become their home (398)

3.3.3. Holding Hope

Participants talked about seeing hope as central to recovery. Hope was seen as the lynch-pin holding service users' current circumstances and future recovery together.

> PPT1: if people can't see a way forward, then how do you engage them, right, then what's the point? What's the point of getting up-, what's the point of gettingup in the morning and leaving your bed if you don't have a sense of things possibly turning around at some point, if you don't think that there is a way of improving life and moving on from where you are right now? Then, you won't beable to, to engage people in, in, like, a therapeutic journey and their recovery process, if we want to use the word (235)

> PPT4: Um, and I think feeling hope, hope is obviously extremely importantbecause it can, you know, help them, like I said, integrate back into the community, without hope what do they have really? (585)

PPT3: I think hope is-, hope is the bit that, um, is part of-, not the bit, is one ofthe mechanisms that moves someone into recovery (154)

Holding hope for service users was seen as necessary, difficult, and fragile, a balancing act for clinicians to contend with. Hope seemed to be unconsciously negotiated between service users and participants, where participants said that they might elicit or hold hope for service users when they weren't able to hold it for themselves.

PPT2: Um, it depends, yeah, who holds it and when. I mean, I think it varies, youwill have-, I mean, you sense it when you're working with people […] Um, and then there's other people where they perhaps have ambitions and hope about thefuture, and we're the ones feeling hopeless, so I think it really varies depending on the individuals. (52)

PPT7: Yes, I think it can be one of the trickiest parts of our role actually, is holding hope (335)

Service user's ability to 'hold hope' for themselves was seen as challenging, with participants saying that numerous internal and external barriers contributed to this. Barriers included internalized stigma, lack of previous positive experiences, and being 'stuck' in the forensic system. Wider systemic barriers further compounded service user's ability to hold hope.

PPT3: Um, and you can formulate that as a kind of internalised stigma, really, um, because of the messages that someone has been getting from, from their early life, but also from the systems, um, over and over again. That they're stuck,that nothing's gonna change, that they're worthless, um, that they're a patient.

And how, kind of, reducing that must be to a person's sense of self. Um, yeah, and then of course there's the stigma at, like, an even bigger societal level where,you know, forensic, forensic working, you know, it's-, there-, there's change, but it's still profoundly racist, homophobic and sexist. Um, and that has a very real impact on a person's recovery and what's possible […] Um, so I'd say that's the big-, that's a big challenge, and it operates on multiple levels. (297)

PPT1: So then, if you don't have a template, if you have never experienced whatnice or positive life might feel like, so where does your hope come from then? (255)

Participants said that it was difficult for them not to feel hopeless at times, especially when service users were feeling hopeless, participants may feel pulled into a position of hopelessness. Participants' feelings of hopelessness were experienced as mentally exhausting.

> PPT7: I think you can get so caught up in when somebody's feeling really hopeless and they can't see any way out we, as professionals, can feel incrediblyhopeless. Especially because somebody, for example, they might feel hopeless and then reject our help or, you know, um, it really helps to have the team to maintain a sense of hope so that the people we work with can move forward (337).

> PPT4: So, I think it, especially in a hospital setting, when you're there, you know,for twelve hours, it can be-, it can be quite tiring and yeah, sometimes quite frustrating because we're trying to help them but sometimes it, it's not even goodenough. Um, yeah, which can lead to a lot of difficulty. I suppose, and not just a lot of even hopelessness in yourself, 'How am I supposed to help, help this person? (712)

3.3.4. Trauma

Participants spoke about the prevalence of past trauma experienced by service users diagnosed with a personality disorder. The importance of being aware of the impact of and understanding a service users' past trauma was emphasized when understanding service users' behaviour and relationships.

> PPT7: Err, I think what helps, um, when working with personality disorder, not only with the individuals but with the teams, is developing that psychological andrelational understanding and thinking about trauma […] and I think when teams are able to stop and understand and think about people's trauma and the pasts that they've been through, I think that makes a world of difference

> PPT1: Even though they're considered offenders, you know, they're-, they have so much suffering, so much trauma, so much victimisation in their-, in their lives as well, many of them. Not all of them, but it makes it a very, very often, overwhelming and lengthy piece of work for them to, sort of, go back and explore

all of that, and it's-, and, and they have to do it. The system demands
that ofthem, right? (494)

Recovering from trauma was seen as a long, complex process. Participants said that service users' past trauma can influence their ability to receive care from staff and participants spoke of the necessity to be mindful about not repeating service users' past trauma.

PPT8: I think with personalities it gets trickier because you're helping, you know, the idea of recovery from, kind of, your whole development, is a bit of an abstractidea. I, I don't think that means you can't use some of the principles and the ideas, I think it just becomes a bit more complex and, and maybe a bit more of a,a longer process (275)

PPT1: So, when they come here, it's the first time that they experience, err, an environment where people actually care. You know, 'We don't want to harm you.We don't want to do things to you, we want to do things with you (205)

PPT 4: Um, yeah, because like I said, a lot of them have had traumatic experiences and you don't really want to repeat something that they've experienced already. Such as being angry with them or rejecting them orsomething like that (505)

A participant spoke of the dilemmas of replacing personality disorder services with complex trauma services.

PPT6: Well, are we talking about something different? Are we not-, do we just,like, change the whole service just to think about complex trauma?' (424)

3.3.5. Emotional Impact

Participants reported that working in forensic settings with service users with a personality disorder diagnosis, can be stressful and bring up difficult feelings which staff must manage. Participants reported the potential for the work to be traumatising to professionals.

PPT1: for sure, it's difficult, it's challenging. It can be-, can be very draining and, and frustrating at times, um, but I think, if you-, if you believe in this

kind of work, and if you want to be successful in it, then you have to go through theseemotional experiences as well as a staff member. (298)

PPT4: it's quite interesting to work with somebody who has-, who presents with apersonality disorder, but it can also lead to a lot of difficulty in unsteady feelings, Isuppose, in yourself (703)

PPT1: Worse case, it can be traumatic for you as well, you know, like-, sort of, like secondary trauma, um, because of the detailed and meticulous nature in which you can explore, say, someone's X offence. That can be-, can be quite horrific, can be quite gruesome, and then you, you, you go back to it and exploreit in a very detailed way, and, and understand what's, what's happened back then. Um, and, and you have to deal with that as well […] it's unnatural to be exposed to this kind of material on a daily basis, and very often left without answers […]. So, very often, you're left with question marks, you don't find answers (519).

Participants reported that the emotional impact of the work can lead to difficult relational dynamics between team members, which can influence how professionals respond to service users.

PPT7: I suppose of course it's like, you know, even with myself included, I thinkat times of crisis or stress or even, you know, the most reflective, thoughtful practitioner, you know, you can get pulled into all sorts of feelings and patterns and, um, with the people with whom we work (668)

PPT1: and you're exposed to colleagues who struggle with it as well. Um, so thenthat struggle can translate into certain dynamics within staff, and while we do, for instance, have support forums like reflective practice and staff support, sometimes it's not enough. Sometimes those two hours per week are not enough, and things play out throughout the week, and the level of stress and the level of hostility on our side can, can rise and can add to the complexity you haveanyway. Um, yes (534)

Participants said that service users' relational difficulties and problems with maintaining boundaries led to staff distress. Participants spoke of the need to remain aware of their own and patients' emotional states, as well as regulate their own and service users' emotions, which was difficult and draining.

PPT4: It can be quite difficult, um, I suppose there's also a lot of, um, in speakingabout, like, a lack-, a lack of boundaries, um, they can overstep the boundaries quite a bit because obviously boundaries for them are, are very blurry. Um, they have no-, some of them have no sense of boundaries […]. Borderline as well, I suppose there's a lot of, like, anger and acting out. Um, and obviously I think there's just a lot of-, because they can't deal with it themselves, they almost project it onto you. […] I mean personality disorders are really difficult to work with anyway (676).

PPT6: They unconsciously project how they're feeling onto you and that can havean impact on you and how you work with them. Um, but obviously being aware ofthat and being able to manage that in yourself because, you know, we're not the ones who are, you know, we're the ones who are supposed to care for them. We can't let their reactions affect us, um, and that's, I think that's, that's very, very important, um, to not allow that to influence how you respond to them (501)

3.3.6. Creating Relationships

The therapeutic relationship was said by participants to be of paramount importance. Participants stated that establishing or maintaining the therapeutic relationship was 'the most important' part of their work. Participants spoke of the therapeutic relationship as being the mechanism through which recovery can occur.

PPT5: I think trust and a strong therapeutic connection is vitally important so thatyou can work healthily with a patient, otherwise just bang your head against the wall, and everybody banging their head against the other side of the wall, and neither of them understanding each other (100).

PPT6: Vital. It's the most important thing really. Um, and it's the thing that wewe're always working on really (117)

PPT3: As a team who tries to work therapeutically. Um, err, yeah, the relationshipI think is what enables recovery at its core. The relationship with the service, um,

and also individual relationships, individual therapeutic relationships

that theservice user has, um, within the team (75)

Participants spoke of the importance of establishing an open and trusting relationship with service users whilst creating a safe and containing environment. Participants also spoke of the need for relationships and their boundaries to be defined, especially with service users with a diagnosis of personality disorder. Participants talked about the challenging systemic conditions under which they had to forge therapeutic relationships.

> PPT4: To maintain a therapeutic relationship and not a friendship. That, that canbe a bit blurry for them sometimes. Especially like me, I'm there all the time […] And they can learn boundaries over time because a lot of them have come with no boundaries (550)

> PPT5: It's infantilising people by taking away their rights and their responsibilities.We feed them, you know, we, kind of, clean their rooms, and we force them to take medication that we think is going to work. We stop them taking the lovely drugs that they like to take and, erm, we tell them they're dangerous. So, we do alot of that, and then we have to build a relationship (94).

3.3.7. Theme Two Summary

Participants said that service users had a lack of connections outside of hospital and often became attached to the hospital and staff making discharge and the end of this relationship difficult. Hope was held by different people in the therapeutic relationship at different times. Hope and the therapeutic relationship were seen as vital vehicles for recovery to occur through. The prevalence of service user's past trauma was acknowledged and affected how staff related to and understood service users. The relationships that participants held with service users had a significant emotional impact on them. Participants were often being held in parental positions, being required to hold hope in seemingly hopeless situations, contain service users' emotions and help them process

trauma and their emotional states. This was experienced as exhausting, and sometimes distressing for participants.

3.4. Theme Three: Identity: Where Do We Go From Here?

3.4.1 Stigma and Personality Disorder

The personality disorder label was reported by participants to be highly stigmatizing, both within the mental health system and wider community; although, it was recognized that some progress had been made. Stigma was something that participants felt the service users with a personality disorder diagnosis experienced repeatedly throughout their lives, over multiple levels. Participants also reported that service users are doubly stigmatized because of their offending history and forensic identity. Through the labels of personality disorder and offender, participants reported that internalized stigma affected how service users viewed themselves.

> PPT1: Yes. Um, I mean, I'm, I'm thinking of-, I'm, I'm thinking of stigma of course.I think it's, it's generally still a massive problem in, in mental health, um, but then when it comes to personality problems, or personality disorder, to stick with the diagnostic label, even within the wider mental health community, it's highly stigmatised. There's still quite a pessimistic outlook (701)

> PPT3: Um, and you can formulate that as a kind of internalised stigma, really, um, because of the messages that someone has been getting from, from their early life, but also from the systems, um, over and over again. That they're stuck,that nothing's gonna change, that they're worthless, um, that they're a patient.
>
> And how, kind of, reducing that must be to a person's sense of self. Um, yeah, and then of course there's the stigma at, like, an even bigger societal level where,you know, forensic, forensic working, you know, it's-, there-, there's change, but it's still profoundly racist, homophobic and sexist. Um, and that has a very real impact on a person's recovery and what's possible. (297)

PPT8: I think, you know, we're making a lot of headway with stigma of mental health, but actually we need to put in the-, the added stigma of having a criminalconviction (90)

PPT3: And, so yeah, I think there's a, sort of, err, an intersection there when forensic meets PD, that is a, sort of, doubly stigmatising, and I think that's a realchallenge (493)

The personality disorder label was also reported to be all encompassing compared to other diagnostic labels, with Service users becoming 'personality disordered'.

PPT1: It becomes-, you know, the labels sort of define who you are. It happenswith all kinds of mental health labels, but I feel like it's certainly heightened with,with the personality disorders, because that's who you are. That's a personality,right, that's who you are. (740)

Participants said that there were some common narratives and beliefs around working with service users with a personality disorder diagnosis, which could make the process of recovery more difficult. There were narratives around 'personality disorder' being more difficult to work with and accordingly having lower expectations in relation to recovery.

PPT5: It's a classic personality disordered man who comes in overnight into a general psychiatric ward, probably intoxicated, claiming to be suicidal and havinga history of doing that, and of being not liked, or dislikeable (185)

PPT5: So, I think your expectation has to be lower, but not that there's an absence of expectation the person will change, but that you're lowering, and youhave to be quite careful about what you do define as, you know, the markers of change and, erm, recovery (322)

PPT4: So, I suppose, important to be aware of that when working with them because personal disorders very-, can be very difficult and complex to work with(132)

Participants commented that individuals with a personality disorder diagnosis are often perceived to be 'higher functioning' compared to Service users with a psychosis diagnosis, however, they may also be seen as manipulative.

PPT8: you know, a lot of our guys with personality difficulties can achieve that actually maybe a bit quicker than our guys with mental health difficulties. They haven't got the negative symptoms, they're more high functioning sometimes, you know, they can, they can, kind of, tick those boxes and they get moved on (335)

PPT7: I'm just trying to think generally of the rule anecdotally, do people with psychosis have more empathy than people with a personality disorder? Um, perhaps, maybe. Um, you know, there might be kind of like a narrative of, 'They're unwell, they don't understand.' Or, you know, whereas people with a personality disorder there could sometimes be a narrative of, 'They're doing thaton purpose or they're winding me up or, um, they're manipulative.' (534)

Although participants tended to report that diagnosis *per se* were not very useful, participants often referred to them when describing service users in the interviews.

PPT6: I think it can be useful as, like, a short cut, um, in the team for thinking about different, sorts of, problems, so we noticed that we struggled more with borderline, borderline patients, um, rather than, kind of, straightforward-, what wesaw as more straightforward anti-social men (399)

3.4.2. Forensic Identity

Participants commented that part of the recovery process for service users with a personality disorder diagnosis was to develop or change their offender identity, moving from anti-social or violent aspects of their identity to a more pro-social one. Participants commented on being involved in this process, which had to be balanced with being non-coercive and service user led.

PPT6: um, and I guess they, they are working on changing themselves as well and developing, building up different parts of their identity and, sometimes, I thinkour risk assessments can feel to them like we're holding them back, um, or just not letting them move on, not letting them change (269)

PPT2: people who found themselves an alternative identity to some extent, youknow, that wasn't criminal or a violent person, […] But it is very difficult

for some people to get beyond the, sort of, position that they've always, kind of, adopted,either in relationships or within society as a whole. (306)

PPT8: Err, I think as well that with a lot of our guys in forensic populations is-, istrying to, you know, the life they had before is not maybe the life that, you know,you're, kind of, veering quite the way-, they haven't really thought about, err, thevalues in a pro-social way and it can be-, err, that's quite a big work in of itself. (92)

3.4.3. Theme Three Summary

The personality disorder label was perceived by participants as still being highly stigmatizing for service users who were doubly stigmatized through being identified as an offender as well. Part of the recovery process was identified as moving and developing their 'offender identity' towards more prosocial values.

3.5. Theme Four: Working with Systems: Where the Power Lies.

3.5.1 The Forensic System

Participants spoke of the huge demands that being detained in the forensic system places on service users, which can impact upon and therefore slow their recovery. It was also experienced as a heavy burden for participants to bear witness to.

PPT1: If quite a bit of your energy and quite a bit of your-, of your focus of that dedication is being taken away because you're, you're mindful of how the systemis treating you, or the circumstances under which you are supposed to recover, that takes a lot of energy out of you, and it's something you have to deal with every day for, for weeks, months, years, right? The average journey through secure systems is, is so many years long. It's, it's massive, especially in the UK. It's, it's quite striking. So, that takes a massive toll on people, (423)

PPT2: The structure of the institution, you know, the fact that people are lockedup in a, in a secure institution, can, kind of, negatively impact on their, sort of, capacity to recover (191)

Participants commented on the lack of 'choice' for service users, or choice being disingenuous which created a sense of conflict within participants.

PPT2: there is obviously the tension in forensics, and I-, because there's such anemphasis on choice, and patient choice, I have always been a bit cynical about the-, err, whether it's a, sort of, slightly disingenuous term to use with patients, because we don't give them a lot of choice about lots of things […] that's one of the things that you can fall foul of in forensics, giving people the impression they're making their own decisions, when actually you're not giving them much choice because you're coercing. (29)

Participants reported that individuals with a personality disorder diagnosis found negotiating the various systems more difficult, which could lead to them becoming 'stuck'. Service users were often met with negative reactions from staff in those systems because of their diagnosis. Getting through 'the system' if you have a personality disorder diagnosis was regarded in itself as an achievement.

PPT2: And so, I think you can get caught in that system if you have personality disorder, because people don't like you very much when they meet you. (234) PPT5: their relationship with the prison system and the criminal justice system is, is the barrier that is virtually impossible to get over in some cases. And again, justgetting out of that system would be-, would perhaps be an indicator of recovery alone (235).

Participants also spoke about feelings of 'stuckness' and frustrations, working between different systems and the various tensions between them.

PPT8: doing recovery models in a forensic service, because you've got this whole other, err, kind of, layer of complexity with the criminal justice system, andI suppose they're, - yeah, but I don't think those things are married up very well (132)

PPT3: Um, I think the challenge can be when you're then interfacing with otherservices. Um, um, particularly in a-, that feels particularly live when you're in a

community context and you're trying to move people on, […] But they're sayingno, because this person is really complicated to work with because of this-, because they've got anti-social, borderline, narcissistic, and psychopathy personality presentations, um, you know, that kind of thing. (500)

3.5.2. Medical System

Participants reported that one of the reasons that service users with a personality disorder diagnosis can get 'stuck' is the medically oriented system in which they are placed, where the primary intervention for individuals is psychological therapy. Many staff commented on a barrier to recovery was being willing or able to engage in psychological therapy.

> PPT4: So, he's stuck. He's just stuck basically. He obviously is not medicated. Hedoesn't see the point in getting therapy. So, what do we do about that then? If he-
> , how, how is he supposed to recover, how is he supposed to help himself? (818)
>
> PPT2: you end up with people in forensic services with personality disorder, and you might have some ideas about the treatment they want, but they end up beingdetained for a long time without really having any treatment, because they are not willing or ready to engage in that kind of treatment. And, and I think then we lose credibility because we're telling people, 'Oh, we're just preparing you for treatment,' or, 'We're taking steps to try and engage you,' and those kinds of things, and that's fine if it's voluntary, but it isn't. It's compulsory (285)

Diagnostic categories were reported by staff as less useful and diagnoses were treated with suspicion and held more broadly. Traditional medical language was regarded with some scepticism.

> PPT6: You know what? I'm not really sure, um, err, because I think sometimesthe diagnosis is a little bit, like, the difference is a bit arbitrary. […] Um, but I wouldn't say that regardless of what we decided or what label they had that recovery or treatment wouldn't be that much different (315)
>
> PPT2: this idea of primary and secondary diagnoses, which is

obviouslynonsense (267)

PPT7: it doesn't have to be like that they're completely cured. I
mean, I don't thinkanybody thinks like that these days, that
somebody has been completely cured from their symptoms and so
on (275)

3.5.3. Power

The power differential that they had experienced were explicitly and implicitly
present in responses. Participants said that they felt both positioned as being
very powerful, whilst also experiencing feelings of powerlessness when working
within 'the system'.

PPT6: but we've got keys. They don't have keys. Um, we have to have a
senseof authority, um, and we have to be able to make decisions that they
don't like sometimes. (250)

PPT5: at the point in which you arrive, it's, kind of, very challenging because
we're giving high end meds against people's will or, at least on occasion, or
at least imposing our will on people. And those people have to adapt to our
rules, and, erm, you know, it's what we do to a certain extent, potentially-,
and we can'tstop ourselves. (90)

PPT2: So, there's quite possibly-, and again it's linked not just to the-,
what itmeans for recovery for the individual, but what the system allows.
(328)

Staff commented on the lack of control and power service users have over their
life and questioned whether the power and control imposed on service users has
the potential to violate human rights.

PPT1: one of the words you hear pretty much every day is, is 'power', is
'authority'. You know, we have to-, people have to ask to go to the toilet.
You know, it's very simple things. People have to ask to use the kettle, boil
some water. 'Can I use the kitchen? Can I go here? Can I go there?' I
mean, they can'tmake 20, 25 steps without someone having to unlock a
door. It's such restricted life. (393)

PPT 1: um, is that excessive or is that even-, is that even illegal? You know,
to what extent are, are basic human rights being violated here? Um, so yes,
the, thesecure nature of our services has a-, has a massive additional impact

on, on people, because not only do you have to deal with your struggles, but you also have to deal with the level of control that's being imposed on you. (348)

3.5.4. Risk

Risk assessment is seen by staff as very important: Participants felt that this was the "bread and butter" of what forensic services do. A lot of responsibility is placed on staff who conduct risk assessments.

> PPT1: everything revolves around risk, at the end of the day. It's the-, it's the most important thing we have to do, is-, that's, that's part of the recovery journey,right? What's, what's your current level of risk when you come here, and then what can we do about it? How much can we bring it down to get to a point wherewe can say, 'Okay, your risk levels are so low that we are confident that, you know, based on the evidence base and based on all the expertise that's been used here, you don't have to be here anymore (455)

> PPT3: Um, because we're, as staff, the ones who're-, who are, kind of, accountable for future risk, um, given that we're the ones who are responsible fordoing risk assessing, […] And, you know, we work in a healthcare context that is increasingly litigious, (345)

Staff experienced risk and recovery as having a highly intertwined, complex relationship with inherent tension: Risk and recovery may conflict with each other, and risk reduction may be equated to recovery.

> PPT7: I think the-, in an ideal world recovery is such an essential part of riskassessment and risk management (188)

> PPT3: I would say that it is the case that there is a tension there in working in arecovery-focussed way, and also, um, doing risk, sort of, management work onthe ground sometimes (357)

> PPT8: But then there's obviously a-, they clash so much with some of our professional ethical code of conduct, in keeping our patients and services at-, ourcore interest, because, you know, we're thinking about the wider-, the safety of the wider population. So, I think, well, we're holding risk to others in mind that might work against the needs of the service user (113).

The forensic system was said by participants to be risk focused and risk averse, which had a negative impact on service users' length of stay and recovery.

> PPT1: risk-related work, again, is, is very lengthy, and for, for both, you know,media-related, societal, political reasons, the risk-averse nature of, of servicescan, can extend stays (473)

> PPT2: because our patients are all high-risk on risk assessments, so in some ways it's meaningless, but that you end up being risk-averse, and that your decisions are driven by that, rather than by some idea of recovery. But the-, butthat's the big-, a big conflict. (139)

Risk assessment was also seen as something that was 'done to' service users and participants instead advocated for further integration of service users' participation into risk assessment.

> PPT8: I think there may be actually need to be a much-needed piece of work-, bigger piece of work thinking about how we use risk assessments and how we include Service users in the risk assessment and in their recovery and, kind of, join those things up a bit more together. I don't think that happens at the moment;I think they're quite standalone, separate things (124)

3.5.5. Theme 4 Summary

Participants experience the forensic system to place huge restrictions on both professionals and service users and is often in direct conflict with recovery model (e.g., choice, empowerment). Individuals with a personality disorder diagnosis can become 'stuck' in the system and tensions between different systems can compound the problem. Participants spoke of being positioned both as having a lot of power and having very little power within the system. Participants reported experiencing the system as privileging risk over recovery.

3.6. Connections Between the Themes

The themes identified through thematic analysis were highly interconnected and integrated with each other as can be seen by the revised thematic map (appendix 9).

'Theme four: Working with systems' seemed to hold power and influence the other three themes and appeared to determine the parameters of possibilities for service users in terms of their recovery and subsequently their relationships, and identity. The 'systems' theme influenced what connections service users had access to and the quality of these relationships, whether these be therapeutic relationships with staff or family or community-based relationships.

The 'system' was seen as having a big impact on 'identity', with service users often being identified as part of criminal justice system and the mental health system, with corresponding labels. The 'system' could also be seen to limit or restrict the possibility developing a new identity. The stigma and trauma associated with these 'identities' could be seen to connect with 'relationships' and service users' abilities to form and utilise these relationships for 'recovery'.

Hope can be seen as a two-way bridge connecting relationships and recovery together. Relationships were reported to provide a strong source of hope which could help enable 'recovery' for service users.

4. DISCUSSION

4.1 Overview

This study explored forensic staffs' experiences of using 'recovery' ideas while working with individuals with a personality disorder diagnosis. Here, the findings are discussed in relation to the research questions and within the context of previous literature and conceptual frameworks. A critical review is provided, and implications for clinical practice, policy and future research outlined.

4.2 **Research Questions, Outcomes and Previous Literature**

4.2.1 "What are staff experiences of 'recovery' in forensic settings with service users with a diagnosis of personality disorder?"

Participants reported defining 'recovery' problematic, and so they struggled to determine whether they used recovery ideas in clinical practice. Participants wondered what service users were supposed to be 'recovering' from. This accords with previous research in this area which criticizes the 'recovery model' for being vague and overly ambitious (Beresford, 2015). When participants offered descriptors of what recovery meant to them, these fitted well with Leamy's (2011) conceptual framework for recovery processes: connectedness, hope, identity, meaning, empowerment and spirituality. This suggests that participants may value certain processes which fall under the umbrella of recovery but may feel the term recovery is not in itself useful. This may also be why staff use recovery ideas in what they felt was a less structured and less explicit way.

Historically, 'recovery' has been associated with health outcomes within the medical approach (Slade, 2009). Participants were clear that service users with a personality disorder diagnosis were not returning to a previous state of health or a previous state of functioning as often their difficulties had been lifelong. Previous literature has suggested *growth* and *healing* as alternative terms (Slade, 2010); however, these also have somatic and medical connotations.

Participants underscored in their descriptions how important it was for the understanding of recovery to come from the individual and not be imposed upon them by staff members. Winship (2016) spoke about how 'recovery' can be hijacked by professionals. Even though the importance of personal meaning is emphasized in most definitions of personal recovery (Anthony, 1993; Leamy, 2011). Prince and Ellis (2020) state that if organizations focus on personal meaning, this can cut through problematic delivery models and ground the management of individuals in a personally held 'narrative'. Recalibrating the power imbalance, towards service user's narrative of recovery, is seen as

particularly challenging for highly controlled forensic settings and likely to raise system anxiety (e.g., Menzie-Lyth, 1966).

Participants talked about the lack of power service users had within the forensic system. They also describing how they felt positioned as very powerful and the responsibility this engendered, as well as feeling powerless as part of the system trying to make meaningful changes. Frameworks such as 'Trauma informed care' (discussed below) seek in part to recognize and address the power imbalance inherent in institutional settings which can lead to the re-traumatization of service users (Muskett, 2014).

4.2.1.1. Connection and recovery

Skett and Barlow (2020) state that relationships are at the heart of all things 'personality disorder'. Participants in this study likewise highlighted meaningful connections within secure settings, and in the community, as being very important for service user's recovery, and these were explicitly linked to hope, which supports previous findings (Davidson & Roe, 2007).

Participants described noticing a lack of family connections for many service users, and sometimes unrealistic hopes for reconciliation, which could result in feelings of rejection, or loss of hope for the future. For one thing, the secure nature of forensic hospitals reduces the opportunities service users have to maintain social support from family members or friends (Barsky & West, 2007), there is also a reported lack of prioritization for family involvement from services (Absalom, McGovern, Gooding, & Tarrier, 2010). Participants highlighted the complex nature of family relationships with service users, especially when violence or abuse has occurred within the family. On the other hand, research has suggested that not all service users benefit from their connections with family and at times family members may impede recovery (EnglandKennedy & Horton, 2011).

Participants described that in the absence of family support, service users could come to view staff members as family, which could lead to them consciously or unconsciously sabotaging their discharge. This idea supports previous research

which has found that a lack of social support can increase anxieties about leaving hospital (Main & Gudjonsson, 2005); whereas increasing family contact is a significant factor associated with a more positive discharge and a shorter stay in secure hospital (Castro, Cockerton, & Birke, 2002). The relationship between service users and staff can be conceptualized through the lens of attachment theory (Bowlby, 1988): staff members can come to provide the principal functions of an attachment figure, by providing a secure place and modulating anxiety (Adshead, 2020). When a service plans to discharge an individual from hospital this can represent real or perceived separation from the staff caregiver stimulating problematic attachment behaviours. The service user may attempt to stop the carer from leaving or attempt to reduce the anxiety caused by the separation; for example, by taking drugs, hurting themselves, or enacting violence on others, in an unconscious or possibly conscious attempt to maintain proximity to the attachment figure.

Whilst the therapeutic relationship was reported as a central vehicle to facilitate recovery, participants also spoke of the multitude of barriers there were to making meaningful connections to staff difficult for service users. These included service users lack of engagement, aggression towards staff, and service user's past trauma, which was linked to difficulties in receiving care, difficulties relating to others and difficulties understanding relational boundaries. These findings support previous research (Mann, Matias, & Allen, 2014) and can also be interpreted from an attachment theory perspective. Gateshead (2020) suggests that individuals may replicate insecure attachment patterns with staff; service users may dismiss or be ambivalent to help that is offered, or painful feelings or threats that arise from attachment relationships may be overwhelming and produce anger and aggression.

Through the therapeutic relationship, participants also spoke of the process of holding and giving hope to service users in an implicitly negotiated 'balancing act'. Drawing on attachment theory (Bowlby, 1988) and mentalization based theory (MBT; Bateman & Fonagy, 2004) the concept of 'epistemic trust' seeks to identify one of the underlying processes through which attachment relationships influence behaviour (Fonagy & Allison, 2014). Epistemic trust is defined as an

"individuals' willingness to consider new knowledge from another person as trustworthy, generalizable and relevant to the self" (Fonagy and Allison, 2014 pg45). It is thought that some individuals (especially those who attract the diagnosis of personality disorder) may have disruptions of epistemic trust and the social learning processes it enables, which results in epistemic 'vigilance'. Fonagy, Luyten, Allison, and Campbell, (2017) asserts that one of the key ways in which epistemic vigilance is overcome is within sensitive caregiving in attachment relationships. Participants in this research may have been describing the experience of working with service users exhibiting epistemic vigilance, and how through their therapeutic relationship, and the giving of hope, they can help service users move towards a position of epistemic trust. In turn this might enable them to think more flexibly, mentalize and move towards recovery goals.

4.2.2.2 Emotional impact of the work on participants

Creating meaningful relational connections with service users is associated with significant emotional labour (Freestone et al., 2015). Participants reflected on the profound impact that working with service users in forensic settings (with a 'personality disorder' diagnosis) can have on professionals. Participants reported being required to witness violence and aggression, as well as helping individuals process past traumas, and discuss their offence history. Participants said the work could be distressing and potentially traumatic, which impacted how they responded to service users. Participants felt that holding and giving hope to service users was often mentally exhausting. This coheres with Ramsden (2020) who suggests that the impact of working with individuals with a 'personality disorder' diagnosis has been underestimated, whilst the capacity of the workforce to manage it has been overstated. Service efforts such as 'reflective practice' spaces often require individuals to be able to notice and address intense emotions; whereas Obholzer and Roberts (1994) suggest that this can ignore the fact that these processes are frequently kept out of awareness by personal and collective defenses (e.g., Menzies-lyth, 1960).

4.2.2. "How does staffs understanding of 'personality disorder' affect their use of the recovery ideas?"

The idea of recovering from personality disorder was contentious for participants in this study. Participants reported that the personality disorder label remains highly stigmatizing, which is consistent with research reporting similar findings (Sibbald, 2020; PDInTheBin, 2019). Although, the perceptions and narratives around personality disorder have shifted considerably over the last two decades (Livesley, 2017), currently, for individuals given a diagnosis of personality disorder, this research suggests that the label itself represents a challenge to overcome in an individual's journey towards 'recovery'. Internalized stigma has been described as a major barrier to recovery (Pyle & Morrison, 2014) and has been described as more disabling than original difficulties (Schulze & Angermeyer, 2003). For individuals in secure settings, who are 'doubly stigmatized' because of their offending history, this represents a significant barrier to recovery. Participants in this study also spoke of discrimination suffered by individuals in secure services with a personality disorder, with services not wanting to accept individuals, based on their diagnosis (Mann, Matias, 2014).

Participants in this study contrasted recovery from personality disorder to recovery from other psychiatric diagnoses; they described recovery from personality disorder as different from other diagnoses, with the label of personality disorder described as more difficult to get rid of, compared to psychosis. Sibbald (2020) similarly states that "you never recover from 'personality disorder', you just learn to live with the difficulties that your early life has thrown at you". Participants further suggested that understanding service users' difficulties within a diagnostic framework limited the applicability of recovery ideas by obscuring personal meaning, which is central to recovery ideas (Prince and Ellis, 2020).

When service users' problems are framed within an individualistic diagnostic framework which is overtly individualistic, interventions and treatments offered often reflect this and are individual and intrapsychic in nature. Participants in this study reported that engaging with psychotherapy was often deemed necessary for individuals with a personality disorder diagnosis to 'recover'. However, participants also said that service users often felt like they had nothing to recover from. The focus on individual therapy became problematic when service users

did not want to engage in therapy. This, participants said, led to service users becoming 'stuck' in the system; and therefore, led both participants and service users to feel helpless and powerless. Service users who do not wish to attend psychological therapy can be labelled as 'refusing to engage' or 'non-compliant' (PDinthebin, 2017). There is an implicit assumption within recovery ideas that individuals want to change intrapsychicly in some way (Slade, 2010). However, previous research has highlighted the difficulties of working with individuals who appear not to want to change, who choose to continue antisocial lifestyles, appearing not to want to understand or change their violent attitudes or beliefs (Drennan & Aldred, 2012). This can lead to increase organizational anxiety, stemming from an inability to 'cure people' (Ramsden, 2020). Mann (2014) suggests that this reliance on a medical, diagnostic driven service, serves the function of reducing system anxiety, by simplifying service users' experiences and increasing professionals' feelings of certainty (which is experienced as containing).

The *Power Threat Meaning Framework* (PTMF; Johnstone & Boyle, 2018) offers a meta-framework and alternative conceptualization to diagnosis, which highlights the links between wider social factors and the resulting longstanding distress. There is no assumption of pathology and the framework seeks to move away from locating difficulties predominately within the individual and situating them within social, cultural and economic contexts which have contributed to pain and distress (Prince & Ellis 2020). The framework seeks to move the conversation from 'what is wrong with you?' to 'what has happened to you?'. PTMF states that 'psychiatric symptoms' (such as emotional dysregulation and aggression) are instead understandable responses to adverse environments and that these responses serve a survival or protective function.

PTMF looks at how 'power' (e.g., biological, interpersonal, economic, social, cultural) has operated in someone's life, and what kind of 'threats' this negative operation of power has posed for the individual. Threats can prevent someone's core needs being met and could be experienced as a threat to emotional, physical, relational or social safety and survival. Meaning is given a central role, with how an individual makes sense of what they have experienced and the world

around them being shaped by social and cultural discourses. What someone had to do to survive (their 'threat responses') are considered understandable and exist for good reason. PTMF also highlights what strengths (power resources) an individual has to draw upon.

The framework has been warmly and widely embraced in many contexts (Jo Ramsden, 2019). However, Ramsden (2019) also suggests that service anxieties for service users to 'engage' and talk about past trauma, could lead services to overinvest in therapy processes and uphold a 'treatment' focus, especially if clumsily applied. This could contribute to increased stigma and exclusion, or for service users to become 'stuck' (as participants in this study have described), if service users do not find therapy meaningful. The current study suggests that participants feel that over investment in psychology and therapy already exists.

The original 'recovery movement' sought to provide a radical alternative to psychiatric care, but attempts to incorporate its principles have been criticized for hijacking the philosophy by professionals, and services stating that they had adopted a 'recovery philosophy' without fundamentally altering practice (Slade & Longden, 2015), this criticism could be repeated with thoughtless application of the PTMF.

The incidence of past trauma in individuals with a personality disorder diagnosis is well known and evidenced (Sweeney & Taggart, 2018), and was drawn upon by participants in this study. The ability for service users to receive 'care' from staff due to their trauma histories was reported in this study and has been reported elsewhere (Adshead, 2018). Difficulties in accepting care could be understood as a form of epistemic vigilance and mistrust (Fonagy and Allison, 2014). The Power Threat Meaning framework (Johnstone & Boyle, 2018) may suggest that epistemic vigilance is an intelligible response to the traumatic experiences that service users have encountered.

The idea of providing trauma informed care has grown in significance over the last few years (Sweeney & Taggart, 2018). The framework dictates the importance of services recognising and acknowledging service users' past

trauma, as well as the potential for services to be retraumatising. However, the idea of replacing the personality disorder label with complex trauma label was met with scepticism in this study. Survivor groups have also cautioned about replacing the personality disorder diagnosis with something arranged around trauma (@SurvivorsNot PD), stating that services could end up pathologizing survival from trauma and repeat a perceived failing of the personality disorder diagnosis whereby individuals are blamed for their own distress (David Pilgrim, 2009). Sibbald (2020) states that although an awareness of past trauma is important, there need to be a recognition that some individuals are not ready to talk about this, and that trauma can come in many forms, not just the 'big T's' of childhood neglect or sexual abuse.

With the emergence of trauma informed care in forensic settings, simply 'bolting it on' to existing frameworks (recovery model, medical model) which professionals report not working for service users with a personality disorder diagnosis could be detrimental. Trauma informed care has been criticized for failing to distinguish itself from medicalized language and therefore, failing to challenge the medicalization of distress and existing systems (Jonhstone & Boyle, 2018). 'Trauma' could become decontextualized and used in a short hand fashion, similar to diagnosis (Jonhstone & Boyle, 2018).

4.2.3 "How does staffs' understanding of 'forensic patient/offender' impact their use of the recovery ideas?"

The labels of 'offender' and 'personality disorder' were reported by participants as being doubly stigmatizing. Through the identities of 'personality disorder' and 'offender', participants felt that internalized stigma affected how service users viewed themselves, with   the potential to define who they were as the labels felt all encompassing. Slade (2009) states that regaining a positive sense of identity is a key feature of personal recovery. Drennan and Aldred's (2012) concept of 'offender recovery' looks at the process of how an individual moves beyond a negative a stigmatizing identity and come to terms with the effect it has had on their self-identity.

Participants in this study spoke about the work they did in relation to the service users' personality disorder diagnosis and the work they did in relation to the service users offending to some extent as existing separately. Previous research has highlighted the additional difficulties and barriers associated with applying recovery ideas to 'offenders' in forensic settings. It may be that staff have split off these additional barriers under an "offender recovery" as suggested by (Drennan & Aldred, 2012). This also reflects the wider and more deeply held divide between the constructs of "mad" and "bad", with the "mad" deserving of treatment the "bad" deserving of punishment (Rogers & Pilgrim, 2010). This was further mirrored by staff associating offender recovery with *risk reduction* and getting out of 'the system'. Again, trauma informed care and the PTMF could both provide useful frameworks to understand and integrate experiences (such as trauma) with behaviours such as violence in one formulation.

Being a 'forensic' service user within the forensic system was considered hugely restrictive by participants, who spoke of the inherent challenges and barriers to applying recovery ideas to this population. Aldred and Drennan (2012) report how the risk of potential harm to others affects all areas of service delivery and has a profound impact on how an individual's care and recovery is approached. Livingston, Rossiter, and Verdun-Jones (2011) state that feelings of oppression and powerlessness are part of the subjective experience of individuals in secure services, which was supported by participants in the present study. Participants described the forensic system as often being in direct conflict with recovery ideas, with choices often described as disingenuous or service users lacking freedom or empowerment, with 'risk' being privileged over recovery.

Risk assessment was viewed by participants in the study as extremely important; the 'bread and butter of forensics'. However, it was also seen to be hugely unbalanced in terms of power, which service users having little input into their assessments. Historically, research has suggested that forensic services utilize more staff led treatment decision making (Borrell-Carrio, 2004) and have struggled with the idea of sharing power. This was supported by participants in this study who spoke of the responsibility of clinicians to be accountable for risk assessments and public protection. Participants also reported an awareness of

the litigious nature of the current climate and broader social and political influences that impact their work.

Arguably, it is incredibly difficult for service users to address their perceived risk, when they are unaware exactly what professionals view their risk to be. Markham (2020) states that under the recovery umbrella, collaborative risk assessments have been recommended by health policy for over 10 years (e.g., Department of Health, 2007), however, there is little research into the application of these ideas in secure forensic units. Markham (2020) state that collaborative risk assessment fits well with recovery ideas, however, systemic challenges such as resistance to change, lack of resources and the perceived expectation that secure services should manage risk and provide social control hinder their implementation in services. Participants in this study suggested that risk assessments can feel to service users that services aren't letting them move on or change their identity, therefore, collaborative risk assessments which are more person centred and hold meaning for the individuals could help to facilitate positive identity change.

4.3 Critical Review

As qualitative research is concerned with meaning in context and acknowledges the role of subjectivity in the research process, it has been argued that the systematic evaluation of the quality of qualitative research represents a considerable challenge for researchers (Willig, 2013). Debate surrounding what constitutes 'quality' in qualitative research have long been argued and numerous quality checklists have been developed (Spencer & Richie, 2017). Trustworthiness is highly valued in qualitative research (Spencer & Richie, 2017). Lincoln and Guba (1985) developed the concept of 'trustworthiness' to include the criteria of credibility, transferability, dependability and confirmability, which have been widely accepted (Nowell, Norris, White, & Moules, 2017). The guiding

principles outlined by Nowell et al (2017) provide a framework for these criteria at each stage of TA and were adopted throughout this study.

4.3.1. Credibility

Credibility represents the fit between the data collected and the findings presented. In this study credibility was addressed in numerous ways. Quotes from participants were included throughout the analysis chapter to provide the reader with evidence of the descriptive accounts. The author also spent a long period of engagement with the data set, used persistent observation and used peer debriefing with the authors supervisor to provide an external check on the research process, as suggested by Lincoln and Guba (1985).

4.3.2. Transferability

Transferability represents the extent to which findings can be generalized to other settings. As it is not always known in qualitative research where findings will be transferred to, thick descriptions of the themes are provided, so that a judgement can be made about the appropriateness of transferring findings.

4.3.3. Dependability

Tobin and Begley (2004) suggest that to achieve dependability, researchers must ensure that the research process is logical, traceable and clearly documented. This can be achieved by evidencing an audit trail (Koch, 1994). The author stored the raw data in secure archives, recorded code generation and development and used diagrams to make sense and develop the connections between different themes (appendix 7) and kept a reflexive journal (appendix 6). An example of an analysed piece of interview transcript is provided (appendix 5) to provide an example of the data analysis process. The audit trail documents how decisions and choices regarding methodological and theoretical considerations were made.

4.3.4. Confirmability

Confirmability refers to establishing the extent to which the researcher's findings and interpretations are clearly derived from the data set. This is achieved when credibility, transferability and dependability have been achieved (Lincoln and Guba, 1985).

4.4. Reflexivity

Reflexivity is perhaps the most distinctive feature of qualitative research (Bannister et al, 2002). A reflexive journal was kept to document both personal and functional reflexivity (Bannister et al, 2002). This included personal reflections and engagement, as well as daily logistical considerations and methodological and rationale decisions.

As noted in the methodology chapter, the authors views, values, biases and personal history etc. will have shaped the research process. As the research is approached from a critical realist position, the findings do not offer a general truth about staff's experiences of recovery with individuals with a personality disorder diagnosis. Interpretations and conclusions are one possible perspective, which is influenced by the authors context as novice researcher and trainee clinical psychologist with experience of working in forensic mental health.

Having previously worked in forensic mental health settings before clinical psychology training in a more junior role, I was aware that staff including myself were asked explicitly or implicitly to help service users recover whilst managing risk and boundaries. I personally grappled with the different expectations and wondered how other staff managed this conflict.

As a trainee clinical psychologist with limited research experience, I was aware that I lacked confidence and felt more comfortable with therapeutic encounters than a research interview. At times I felt uncomfortable when there were assumptions that I was 'expertly' knowledgeable about personality disorder and

the recovery model, I wondered if this meant that I moved interviews on quicker at this point to avoid my own discomfort.

During the interviews I was aware that there were often times when interviewees sought validation for their view point or assumed I shared the same point of view as them. As a novice researcher it was difficult to know how much I shaped interviewees responses by my own verbal or nonverbal responses.

4.5. Ethical and Methodological Considerations

4.5.1. Data collection and social desirability

During earlier research interviews, it seemed participants may have felt that they were being tested on their knowledge of the 'recovery model'. At times it felt as if participants were trying to give 'correct' or 'text book' definitions, rather than their experiences. This was understood as staff feeling they 'should' know what the recovery model is and feared 'looking bad' for not giving 'correct' answers. The author responded to this in interviews with reiteration of the aims of the research and that no 'correct' answer was being sought.

4.5.2. Diversity of participants

This study used a self-selecting sample. Although data on staff ethnicity was not collected, the author noted that all participants appeared to be from white backgrounds. How staff members construct their understanding of recovery is likely to be shaped in part by their cultural influences, and access to privileges. Future research should seek to identify a more diverse population.
Although all disciplines were invited to take part in the research, no Registered Mental Health Nurses (RMNs) volunteered. RMNs are the individuals most involved in the writing of service users care plans and are the service users 'primary nurse' and primary point of contact. They arguably have a large influence on a service users' recovery, but their voice is missing from this

research. Nurses are notoriously difficult to recruit for research studies (Chan et al, 2009), future research should look for ways to maximize their involvement.

4.6 Implications and Recommendations

4.6.1 Individual level

Participants found the concept of recovery to be vague and weren't sure how it related to services users with a diagnosis of personality disorder. Services that utilise recovery ideas may have to identify what they mean by recovery, clearly delineating it from clinical recovery. Leamy's (2011) recovery processes are well evidenced by research and could be used as a framework to define 'recovery'. This would also provide reassurance to staff that they do have a good understanding of recovery, which was questioned by participants in this study.

An alternative way of understanding distress, especially for those diagnosed with a personality disorder is warranted. The diagnosis of personality disorder did not fit with participants understanding of recovery. The PTMF framework provides an alternative framework for understanding distress and is explicitly compatible with recovery ideas (Johnstone & Boyle, 2018). A challenge for the PTMF would be how to balance the hugely unbalanced power dynamics in secure settings (Jo Ramsden, 2019).

Given that the personality disorder diagnosis causes so much controversy, and has huge implications for recovery, there have been calls for the personality disorder label to be used only with consent (Sibbald (2020). Meanwhile, Prince and Ellis (2020) warn that debates surrounding personality disorder and diagnosis can distract us from providing meaningful services. Services should guard against using controversy as yet another systemic defense, enabling the status quo to continue.

Participants were hugely impacted emotionally their work with service users with a personality disorder diagnosis. The emotional impact of the work has the potential to undermine how effective and therapeutic a service is (Ramsden, 2020). Staff need to be better resourced and supported with this. Through creating a supportive team framework, professionals can be supported to retain their 'minds' and continue to mentalise in secure settings under difficult circumstances (Fonagy & Allison, 2014).

The emotional labour (Freestone et al., 2015) required to establish meaningful relational connections with service users who have experienced trauma or have relational problems requires space to be processed through critical reflective dialogue such as staff reflective practices. However, Gordon (2020) warns against creating a narrative in reflective spaces whereby service users are 'othered' and seen as maliciously inflicting distress on 'dedicated and caring staff'. Gordon, (2020) suggests that reflective spaces should be critical of the frames of references and biases bought to them and suggests that co-produced reflective practice spaces could facilitate this.

Participants in this study identified the power inequality that exists between clinicians and service users and how this negatively impact service user's capacity to 'recover'. Ball, (2020) states that services working with people with a personality disorder diagnosis should be moving increasingly towards co production, where the balance of power, responsibility and resources is shifted from professionals to service users. The notion of shared power is particularly difficult for forensic services to conceptualise, and typically raises individual and system anxieties, especially around risk (Shepherd, Doyle, et al., 2016b). Ball (2020) offers the concept of 'good enough practice' in relation to co-production whilst services remain in the early stages of implementing change. Some 'good enough' practices cited by Ball include employing service-user consultants and lived-experience practitioners.

4.6.2. Service level

If relationships are to be at the heart of all things 'personality disorder' as Skett and Barlow (2020) suggest, services need to put relationships at the heart of how they are organized and how they support individuals. As highlighted by participants in this research (and previous findings), services are often organized in such a way that maintaining consistent, effective therapeutic relationships is extremely difficult. Individuals that attract a personality disorder diagnosis often find relationships overwhelming, so additional systemic barriers amplify these challenges. Current pressures on mental health services, including a lack of funding, staff shortages, emphasis on short term care make it harder to establish a secure therapeutic alliance (Cummins, 2018; Tracy et al., 2019). Adshead (2018) argues for services which are 'psychologically secure' which allow sufficient time for service users to 'attach' to services to enable growth and recover. A 'psychologically secure' service would also enable staff to feel 'secure' in themselves and promote staff wellbeing.

Participants in this study highlighted the lack of involvement of service users' families. It is recommended that this is prioritized when indicated by the service user. There is evidence that reduced social support contributes to difficulties adjusting to secure hospitals (McCann, McKeown, & Porter, 1996), and increases anxieties about discharge (Main & Gudjonsson, 2005); but increasing family contact is a significant factor associated with a more positive discharge and a shorter stay in secure hospitals (Castro et al., 2002). Family involvement is also a key risk management strategy used in risk assessment tools such as the HCR-20v3 (Douglas, Hart, Webster & Belfrage, 2013). Secure services lack a clear strategy to implement national policy with the sensitivity and specificity required to address the complexity of such relationships (Williams, 2018). Interventions such as co-produced eco-maps (Ray & Street, 2005), which map out a service user support network, detailing the quality of relationships and what relationships they would like to strengthen, could act as a starting point for increasing involvement.

Participants highlighted the pervasiveness of trauma in service users with a personality disorder diagnosis and the impact this has on recovery, so the continued to adoption of trauma informed care in secure services is supported by

the findings in this study, however, the criticisms and failings of services implementing the recovery model (as talked about above) apply to trauma informed care.

Services should feel able to recognize that personal recovery will not easily be tied to objective, operationalizable and measurable outcomes if it is truly defined by individual service users.

4.6.3. Systems level

Lack of connection was highlighted in this study. Individual level interventions are of limited value, when people are then placed back into impoverished social settings devoid of connections, belonging and meaning. This has been described as the "intervention cliff edge" off which service users fall when discharged (Ramsden, 2020b).

This study supports finding that there is an over reliance on individual therapy, especially in relation to individuals with a personality disorder diagnosis in secure settings. This research adds to the call for acceptance of truly psychosocial ways of working, which is at odds with current procedures and policies in mainstream services. Currently most services for individuals with a diagnosis of personality disorder are informed by the dominant diagnostic framework (Ramsden, 2020a). Services are increasingly being commissioned on singular service specifications and dependent on performance and outcome monitoring (Appleby et al, 2010). The importance of developing partnership working and multiple service collaboration, to stop service users becoming 'stuck' in the forensic system, is warranted.

This research highlighted how staff felt individuals get 'stuck' in the forensic system. Services need to be able to embrace the messiness and complexities associated with the individuals who attract the diagnosis of personality disorder. Participants highlighted service discriminating against service users with a personality disorder, Hirons and Sutherland (2020) state that services are often commissioned with sharp inclusion and exclusion criteria, this will only lead to

those with the most complex of problems remaining 'stuck' and unable to 'recover'.   As this research highlighted the ongoing stigma and discrimination against 'personality disorder' even from other services, collaborations should include offering training on understanding service users' difficulties that have a diagnosis of personality disorder.

Benefield and Haigh (2020) state that resistance to change for secure services is not a viable option. Secure services need to be liberated to help service users 'recover'. The 'problem of personality disorder' must be considered at the social and systemic level (Hirons & Sutherland 2020), the current narrow focus on recovery, must be broadened to connect the personal with the political. Ultimately a preventative public health approach is argued as overdue and necessary (Harper, 2016). This could look at tackling traumatic adverse childhood experiences (ACE's) that individuals experience which puts them at a significantly increased risk of becoming a service user with a personality disorder diagnosis.

4.6.4. Future research

Due to the small sample size, it was not possible to compare participants experiences of recovery ideas across the different disciplines. Future research should look at the extent of agreement or disparities that could exist between different disciplines in their experience of using recovery ideas, as differing conceptualizations and experiences of recovery could have implications for service users. Ramsden (2020) suggests that ill co-ordinated MDT working can be a form of 'social defence' whereby different members work in silos, rather than truly integrating which raises anxieties which may need confronting. Future research could also look at the concepts of 'epistemic trust' and 'epistemic vigilance' within the therapeutic relationships in secure settings and whether service users or staff feel these change over time. This research highlighted staffs' experiences of recovery and previous research has tended to focus on service users experiences, given the highly relational nature of the recovery process, future research could look at interviewing staff and services together to

try and explore this relationship. Conceptual issues surrounding personality disorder remain and have not been clarified by this study.

5. CONCLUSION

The research followed a Thematic Analysis methodology to explore how forensic staff experience using recovery ideas with service users diagnosed with personality disorder. The four main themes identified were: Recovery: Is this what we do? Connections: Being part of something, Identity: Where do we go from here? and Working in systems: Where the power lies. Findings indicate that participants use recovery ideas explicitly and implicitly in the forensic settings with people with a diagnosis of personality disorder and broadly agree with the framework cited in literature. Problematic systems (forensic hospitals, diagnostic system) were described by participants as inherently conflicting with recovery principles which created additional barriers for service users to overcome. Identity, hope and connection to others were seen as central to the recovery process. Implications and recommendations for clinical practice and future research were made.

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APPENDICES

Appendix 1: Participant Invitation Letter

Appendix 1: Participant invitation letter

PARTICIPANT INVITATION LETTER

You are being invited to participate in the following research study: **"Staffs experiences of using the recovery model in forensic settings" (IRAS ID 261949).** Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

The project title is "Staffs experiences of using the recovery model in forensic settings". I am especially interested in staffs experiences of using the recovery model with service users given a diagnosis of personality disorder.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am looking for a broad range of staffs experiences using the recovery model so am recruiting from all staff working within the unit.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to complete an interview asking about your experiences of using recovery ideas. This will take between 45-60 minutes and will be structured like an informal chat. Interviews will be recorded using an audio recorder. The interview will take place within the unit in a private room.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times. Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research. Participants do not have to answer any/all questions asked of them and can stop their participation at any time

What will happen to the information that you provide?

A separate record of participant's names and their data number will be kept for the purposes of identifying and withdrawing the data if necessary. This will be available to the researcher only and kept on a password protected computer. This will be destroyed at the end of the study (September 2020).

Interviews will be recorded on a password protected voice recorder. These will then be transferred and stored on a password protected computer. The recorded interviews will be transcribed anonymously and no names will be used at all. The anonymised data will be seen by the researcher, supervisor, the university and may be published in academic journals. Audio recordings will be destroyed at the end of the study (September 2020) and anonymised transcripts of the interviews may be kept for up to 2 years after the study for the purposes of publication.

Please see page 3 for a statement by the NHS Health Research Authority (HRA) which provides information about The General Data Protection Regulation (GDPR) which came into force on 25 May 2018.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence and have the data you have supplied destroyed on request. However, if you withdraw I would reserve the right to use material that you provide up until the point of my analysis of the data.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Emma Massey   **email: u1622885@uel.ac.uk**

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Matthew Jones-Chesters. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: **m.h.jones-chesters@uel.ac.uk**

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.lomas@uel.ac.uk)

This information document/leaflet explains how health researchers use information from patients. If you are asked to take part in research, you can ask what will happen in the study.

What is patient data?

When you go to your GP or hospital, the doctors and others looking after you will record information about your health. This will include your health problems, and the tests and treatment you have had. They might want to know about family history, if you smoke or what work you do. All this information that is recorded about you is called patient data or patient information.

When information about your health care joins together with information that can show who you are (like your name or NHS number) it is called identifiable patient information. It's important to all of us that this identifiable patient information is kept confidential to the patient and the people who need to know relevant bits of that information to look after

the patient. There are special rules to keep confidential patient information safe and secure.

What sort of patient data does health and care research use?

There are lots of different types of health and care research.

If you take part in a clinical trial, researchers will be testing a medicine or other treatment. Or you may take part in a research study where you have some health tests or answer some questions. When you have agreed to take part in the study, the research team may look at your medical history and ask you questions to see if you are suitable for the study. During the study you may have blood tests or other health checks, and you may complete questionnaires. The research team will record this data in special forms and combine it with the information from everyone else in the study. This recorded information is research data.

In other types of research, you won't need to do anything different, but the research team will be looking at some of your health records. This sort of research may use some data from your GP, hospital or central NHS records. Some research will combine these records with information from other places, like schools or social care. The information that the researcher collects from the health records is research data.

Why does health and care research use information from patients?

In clinical trials, the researchers are collecting data that will tell them whether one treatment is better or worse than other. The information they collect will show how safe a treatment is, or whether it is making a difference to your health. Different people can respond differently to a treatment. By collecting information from lots of people, researchers can use statistics to work out what effect a treatment is having.

Other types of research will collect data from lots of health records to look for patterns. It might be looking to see if any problems happen more in patients taking a medicine. Or to see if people who have screening tests are more likely to stay healthier.

Some research will use blood tests or samples along with information about the patient's health. Researchers may be looking at changes in cells or chemicals due to a disease.

All research should only use the patient data that it really needs to do the research. You can ask what parts of your health records will be looked at.

How does research use patient data?

If you take part in some types of research, like clinical trials, some of the research team will need to know your name and contact details so they can contact you about your research appointments, or to send you questionnaires. Researchers must always make sure that as few people as possible can see this sort of information that can show who you are.

In lots of research, most of the research team will not need to know your name. In these cases, someone will remove your name from the research data and replace it with a code number. This is called coded data, or the technical term is pseudonymised data. For example, your blood test might be labelled with your code number instead of your name. It can be matched up with the rest of the data relating to you by the code number.

In other research, only the doctor copying the data from your health records will know your name. They will replace your name with a code number. They will also make sure that any other information that could show who you are is removed. For example, instead of using your date of birth they will give the research team your age. When there is no information that could show who you are, this is called anonymous data.

Where will my data go?

Sometimes your own doctor or care team will be involved in doing a research study. Often, they will be part of a bigger research team. This may involve other hospitals, or universities or companies developing new treatments. Sometimes parts of the research team will be in other countries. You can ask about where your data will go. You can also check whether the data they get will include information that could show who you are. Research teams in other countries must stick to the rules that the UK uses.

All the computers storing patient data must meet special security arrangements.

If you want to find out more about how companies develop and sell new medicines, the Association of the British Pharmaceutical Industry has information on its website.

What are my choices about my patient data?

- You can stop being part of a research study at any time, without giving a reason, but the research team will keep the research data about you that they already have. You can find out what would happen with your data before you agree to take part in a study.
- In some studies, once you have finished treatment the research team will continue to collect some information from your doctor or from central NHS records over a few months or years so the research team can track your health. If you do not want this to happen, you can say you want to stop any more information being collected.
- Researchers need to manage your records in specific ways for the research to be reliable. This means that they won't be able to let you see or change the data they hold about you. Research could go wrong if data is removed or changed.

What happens to my research data after the study?

Researchers must make sure they write the reports about the study in a way that no-one can work out that you took part in the study.

Once they have finished the study, the research team will keep the research data for several years, in case they need to check it. You can ask about who will keep it, whether it includes your name, and how long they will keep it.

Usually your hospital or GP where you are taking part in the study will keep a copy of the research data along with your name. The organisation running the research will usually only keep a coded copy of your research data, without your name included. This is kept so the results can be checked.

If you agree to take part in a research study, you may get the choice to give your research data from this study for future research. Sometimes this future research may use research data that has had your name and NHS number removed. Or it may use research data that could show who you are. You will be told what options there are. You will get details if your research data will be joined up with other information about you or your health, such as from your GP or social services.

Once your details like your name or NHS number have been removed, other researchers won't be able to contact you to ask you about future research.

Any information that could show who you are will be held safely with strict limits on who can access it.

You may also have the choice for the hospital or researchers to keep your contact details and some of your health information, so they can invite you to take part in future clinical trials or other studies. Your data will not be used to sell you anything. It will not be given to other organisations or companies except for research.

Will the use of my data meet GDPR rules?

GDPR stands for the General Data Protection Regulation. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules.

Universities, NHS organisations and companies may use patient data to do research to make health and care better.

When companies do research to develop new treatments, they need to be able to prove that they need to use patient data for the research, and that they need to do the research to develop new treatments. In legal terms this means that they have a 'legitimate interest' in using patient data.

Universities and the NHS are funded from taxes and they are expected to do research as part of their job. They still need to be able to prove that they need to use patient data for the research. In legal terms this means that they use patient data as part of 'a task in the public interest'.

If they could do the research without using patient data they would not be allowed to get your data.

Researchers must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

What if I don't want my patient data used for research?

You will have a choice about taking part in a clinical trial testing a treatment. If you choose not to take part, that is fine.

In most cases you will also have a choice about your patient data being used for other types of research. There are two cases where this might not happen:

1. When the research is using anonymous information. Because it's anonymous, the research team don't know whose data it is and can't ask you.
2. When it would not be possible for the research team to ask everyone. This would usually be because of the number of people who would have to be contacted. Sometimes it will be because the research could be biased if some people chose not to agree. In this case a special NHS group will check that the reasons are valid. You can opt-out of your data being used for this sort of research. You can ask your GP about opting-out, or you can find out more.

Who can I contact if I have a complaint?

If you want to complain about how researchers have handled your information, you should contact the research team. If you are not happy after that, you can contact the Data Protection Officer. The research team can give you details of the right Data Protection Officer.

If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

Appendix 2: Participant consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

IRAS ID: 291949

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Staff experiences of using the recovery model in forensic settings with individuals with a diagnosis of personality disorder.

Name of Researcher: Emma Massey

	Please tick
I have the read the information sheet dated 21/06/2019 (version 1.0) relating to the above research study and have been given a copy to keep.	
The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information.	
I understand what is being proposed and the procedures in which I will be involved have been explained to me.	
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.	
I hereby freely and fully consent to participate in the study which has been fully explained to me.	
Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.	

I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.	

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………….

Participant's Signature

…………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

…………………………………………………………………………………..

Researcher's Signature

……………………………………………………………………………………

Date: ………………….…….

<u>Appendix 3: HRA Approval Letter</u>

03 October 2019

Dear Ms Massey

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **Staff experiences of using the recovery model in**

forensic settings with individuals with a diagnosis ofpersonality disorder.

IRAS project ID: 261949

Sponsor   **University of East London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval**has been given for the above referenced study, on the basis described in the application form,protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towardsthe end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Irelandand Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report(including this letter) have been sent to the coordinating centre of each participating nation.
The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in NorthernIreland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work withyour non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRAwebsite gives detailed guidance on reporting expectations for studies with HRA and HCRWApproval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light ofchanges in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact detailsare below.

Your IRAS project ID is **261949**. Please quote this on all

correspondence.Yours sincerely,

Kelly

Row

e

Appr

ovals

Man

ager

Email: hra.approval@nhs.net

Copy to: *Mrs Catherine Hitchens*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor public liability]		24 May 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Employer liability]		
Interview schedules or topic guides for participants [Interview schedule IRAS 261949 210619 V1]	1.0	21 June 2019
IRAS Application Form [IRAS_Form_17092019]		17 September 2019
Organisation Information Document [Organisation Information Document]	1.1	25 September 2019
Other [Emma Massey Ethics Review Decision Letter]	1.0	25 February 2019
Other [Debrief sheet]	1.0	21 June 2019
Participant consent form [Consent form]	1.1	25 September 2019
Participant information sheet (PIS) [Participant information sheet IRAS project ID 261949 document date 21062019 version 1.0]	1.1	25 September 2019
Referee's report or other scientific critique report [Ethic review letter IRAS 261949]	1.0	11 January 2017
Research protocol or project proposal [Research proposal]	1.0	09 November 2017
Schedule of Events or SoECAT [HRA schedule of events IRAS 261949 V1 Date 210619]	1.1	25 September 2019
Summary CV for Chief Investigator (CI) [Chief Investigator Emma Massey CV IRAS project ID 261949 document date 210619 version 1.0summary]	1.0	21 June 2019
Summary CV for student [Student Emma Massey CV summary]	1.0	21 June 2019
Summary CV for supervisor (student research) [CV MJC]	Final	26 April 2019

Appendix 4: UEL School of Psychology Ethics Review Decision Letter

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION
For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Anna Stone

SUPERVISOR: **Rachel Smith**

STUDENT: Emma Massey

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: What are staff experiences of using the recovery model in forensic settings with service users given a diagnosis of personality disorder?

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Minor amendments

Minor amendments required *(for reviewer)*:

> The ethics application specifies that the target participants are individuals using the Recovery Model in their work in a forensic setting. Yet, one of the questions on the interview schedule asks if the participant has used the Recovery Model. Please clarify how the participants are to be recruited.
> The last sentence of question 17 (withdrawal) is ambiguous. Please re-phrase.

Confirmation of making the above minor amendments *(for students)*:

> I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.
>
> Student's name *(Typed name to act as signature)*:   EMMA MASSEY
> Student number: U1622885
>
> Date: 31/05/2019
>
> *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

If the proposed research could expose the <u>researcher</u> to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

[ ]   HIGH

> Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

[ ]   MEDIUM (Please approve but with appropriate recommendations)

[x]   LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*:   Dr Anna Stone

Date: 25th February 2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

<u>RESEARCHER PLEASE NOTE:</u>

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

1. A copy of the approval of your initial ethics application.

Name of applicant: Emma Massey

Programme of study: Professional Doctorate in Clinical Psychology

Name of supervisor: Dr Matthew Jones-Chesters

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale

Old Title: What are staff experiences of using the recovery model in forensic settings with service users given a diagnosis of personality disorder?	It was thought that the second title read better.
New Title: Staff experiences of using the recovery model in forensic settings with individuals with a diagnosis of personality disorder.	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	Yes	
Does your change of title impact the process of how you collected your data/conducted your research?		No

Student's signature (please type your name):   Emma Massey

Date: 03/06/2021

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	
Comments		

Reviewer: Trishna Patel

Date: 04/06/2021

Appendix 5: Coded text

(Coding comments in balloons)

Emma: Yes, that's fair enough. Um, do you think there's differences in using recovery and recovery ideas in forensic settings?

PPT: Um, I mean it's hard for me to completely say because I've worked in a forensic setting for so long. Um, I mean, I suppose-

Emma: Or what are some of the barriers that your guys face?

PPT: Yes, um, well the first thing that comes to my mind is-, there's-, I don't (inaudible 07.46) to say-, I wasgoing to say the multiple agendas, but I don't know whether that's that way of what needs to be, kind of, achieved when people come to where we work. So, um, we're working with individuals to help, um, them with the distress that they've experienced that have led them to commit an offence or, um, to end up in a secure unit but we've also, um, got to think about risk and keeping other people safe. Um, and, of course, that shouldn't be-, recovery shouldn't be excluded. You know, you can't think, 'Well, we don't need to think about (inaudible 08.21) recovery when we're thinking about that, because it's so intertwined actually. Um, but I think it's-, yes, so I think-, I don't know whether the dialogue about recovery is dampened down in forensics settings sometimes because of that. I'm not sure, I mean, I suppose, um, barriers within a forensic setting, you know, I think a lot of the psychiatrists I have worked with are very balanced in their thinking, actually, and there are not that many psychiatrists that I've come across these days who are, kind of, completely medicalised. Um, I do think there is still narrative that, um, people have a mental illness that need to be treated. Um, and quite often that is that those people need to have treatment for their mental illness. But I think, like I said before, I think there needs to be much more subtleties where perhaps the recovery model way of thinking can be really helpful. Um.

Emma: Yes. Definitely. So, um, you kind of mentioned this bu risk assessments influence recovery and the work that you try

PPT: Again, I think-, yes, no, I think the-, in an ideal world

recovery is such an essential part of risk assessment and risk management. I think what I find from my experience of filling in forms like HR20s and so on is that thinking, formulating and understanding somebody's risk is paramount, which is really important. So, I don't know whether you're familiar with HR20-, (TC 00.10.00)

Emma: Yes.

PPT: But you've got twenty risk factors and then you think about and you get evidence for those twenty risk factors and you think about formulation and then towards the end is a risk management plan. And I often, kind of, say that sometimes we should do it the other way round and we should think about, um, you know, the kind of-. I guess what people can do in a positive sense and I wonder from-, and maybe I'm confusing this with the recovery but, for me, perhaps this is where recovery comes into to think about, you know, what can we do for somebody's recovery and how can that help manage the risk where sometimes I think the way that risk assessments are designed, you're so much focusing on the risk, what people have done-

Emma: Yes, yes.

Appendix 6: Reflective Journal

Except after interviewing participant 3:

"PPT seemed quite anxious to begin with, but relaxed as interview progressed. Clear to see the emotion behind her responses and a passion for the work that she does.

Really struck by the participants comment that it is 'important to know what motivates you to do the work' Constant need to mentalise and reflect, be ever present? Is this even possible? Surely staff must need to detatch/numb/avoid, something to cope/survive?

Made me think about the attachments with staff – thinking about unrealistic expectations of attachments -various attachments to other patients/staff/family. Is therapeutic relationship different from attachment? Should I collapse famil/therapeutic relationship/attachments into one – attachment to others? (FOR SUPERVISION).

PPT spoke about creating secure attachments – the demand on staff to be continually reflective to contain, to regulate emotions and be aware of service users emotional state – feeds into the emotional impact on staff… much deeper than just physical violence/verbal abuse. Constant explicit mentalization that is required. Obviously not always possible. Guilt? Burnout?

The idea offending to get back into prison doing what you need to get that attachment…"

Connection??? How do you establish connection to something, to something bigger and wider than yourself – when you are severed from everything?? Connection/attachments/relationships….. These are the difficulties in the individual already – anything remaining is then stripped from them when they enter the system… any connections connected to an antisocial identity are stripped… they then have to establish and grow connections from the confines of the system (huge amount of boundaries around relationships) within the remits of the MH system and what the MOJ and MH system find acceptable… Feel quite exhausted and hopeless and anxious after the interview.

Appendix 7: Coding process

Initial codes were generated through reading and re-reading of interview transcripts. Initially 59 different codes were generated. Whilst recording initial codes. I also noted initial ideas and any potential themes that were emerging in my journal.
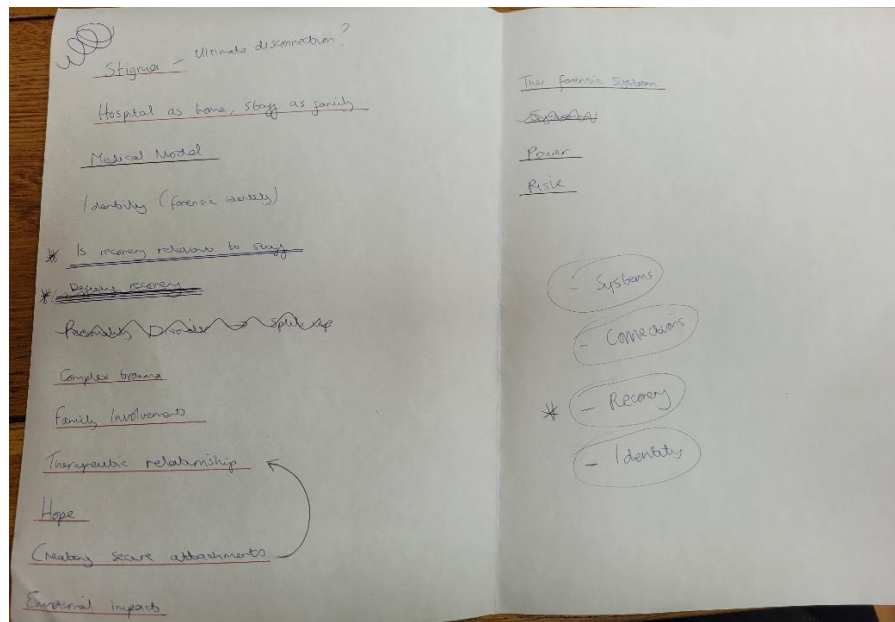

From the initial list, the codes were refined. For example "ward is safe", "community is scary", "staff as parents" was incorporated under the code "hospital as home, staff as family".
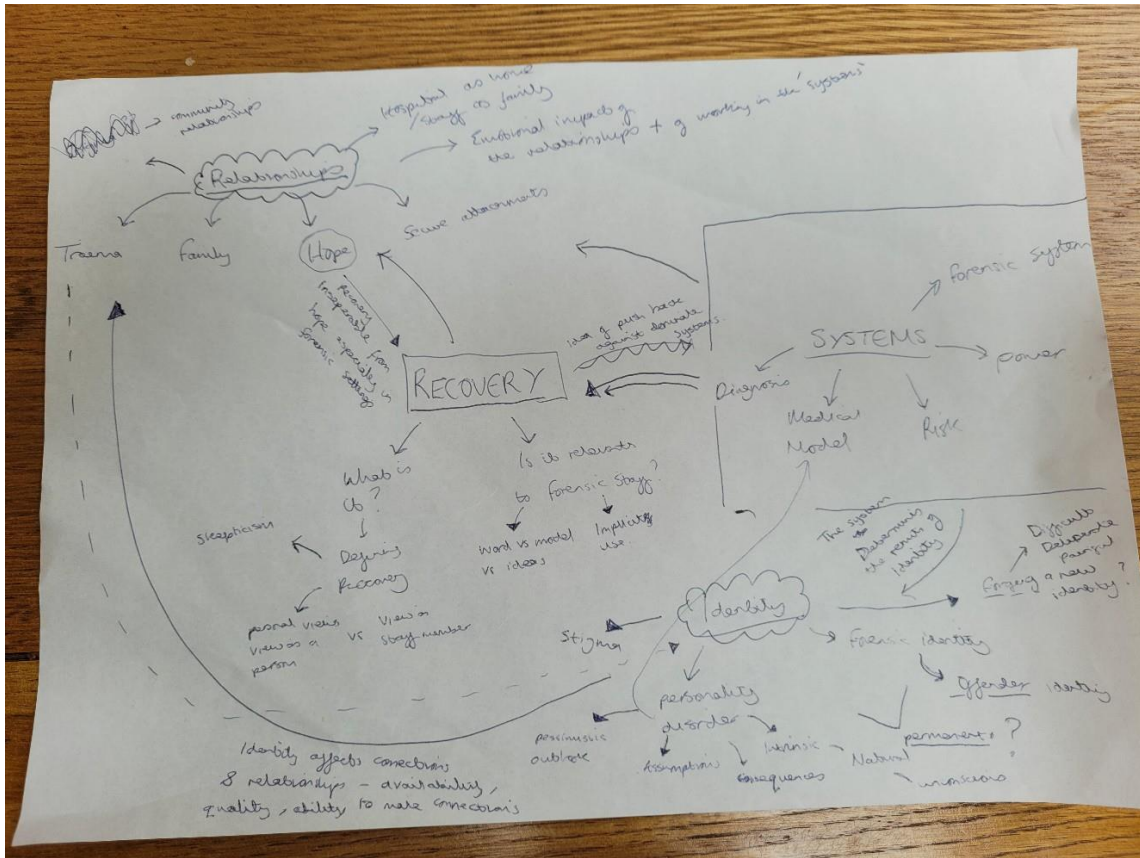
Final codes were:

Defining recovery
Using recovery ideas

Hospital as home, staff as family
Family involvement
Hope
Emotional impact
Trauma
Therapeutic relationship
Stigma
Forensic identity
The forensic system
The medical system
Power
Risk

Potential themes were then identified, reviewed and defined by the author and then discussed in supervision. Data was then collated for each theme to check that the data supported the themes.

Appendix 8: Initial thematic map

Appendix 9: Final Thematic Map

WORKING WITH SYSTEMS

Forensic system   Medical system   Power   Risk

RECOVERY

Defining recovery   Using recovery ideas

CONNECTIONS   IDENTITY

Hospital as home,   Family involvement   Stigma

staff as family   Forensic identity

Hope

Emotional impact

Trauma

Therapeutic relationship