Title: Nurses' perceptions of personal attributes required when working with people with a learning disability and an offending background: a qualitative study

Abstract

Aim: To identify and discuss the personal attributes required by learning disability nurses to work effectively with people with an offending background in secure and community settings.

Background: This paper was part of a larger research investigation into the nursing competencies required to work with people with an offending background. There are few existing studies examining the personal attributes necessary for working with this group.

Design: A qualitative study addressing the perceptions of nurses around the personal attributes required to work with people with learning disabilities and an offending background.

Methods: A semi-structured interview schedule was devised and constructed, and thirty-nine individual interviews subsequently undertaken with learning disability nurses working in high, medium, low secure and community settings. Data were collected over 1-year in 2010/11 and analysed using a structured thematic analysis supported by the software package MAXqda.

Findings: The thematic analysis produced three categories of personal attributes, named as looking deeper, achieving balance and connecting, each of which contained a further three sub-categories.

Conclusion: Nursing of those with a learning disability and an offending background continues to develop. The interplay between personal history, additional background factors, nurses' personal attributes and learning disability is critical for effective relationship building.

Keywords: competencies, learning disability, nursing, offending, personal attributes, secure setting

Accessible Summary

What is known on the subject?

- Learning disability nursing in the area of people with a learning disability and an offending background has developed considerably over recent years, particularly since the publication of the Bradley Report (2009).
- There has been limited work into the competencies nurses require to work in this area, and even less about the personal attributes of learning disability nurses.

What this paper adds to existing knowledge?

- Learning disability nursing's specific contribution to the care of this population lies in their knowledge of the interaction between the learning disability, an individual's,

sometimes abusive, personal history, and an understanding of the subsequent offending behaviour.

- The knowledge base of nurses working with people with learning disabilities and an offending background needs to reflect the changing service user group. This is particularly in relation to substance misuse, borderline personality disorder, and mental health and the way such factors inter-relate with the learning disability.

What are the implications for practice?

- Further research is required into the relationship between decision-making, risk taking, or reluctance to do this, and the personal attributes required by nurses to work in secure learning disability care.
- Learning disability secure services are likely to continue to undergo change as circumstances alter and the offending population demonstrate greater complexity; nursing competencies and personal attributes need similarly to adapt to such changes.
- Mental health nursing has a great deal to contribute to effective working with this population, specifically with regard to developing strong relationships when concerns around borderline personality disorder or substance misuse are particularly in evidence.

INTRODUCTION

There has been considerable interest over several decades in the need to identify core competencies in nursing (Boyatzis, 1982; Carlisle *et al.*, 1998), with some authors including personal attributes amongst the more competency-based areas of clinical skills and problem solving (Norman, 1985). Key competency areas in learning disability[1] nursing in the context of secure care have been identified as knowledge assimilation, team working, communication and decision making (Lovell *et al.*, 2014). These authors also suggest that service users have changed over recent years, becoming younger, less severely learning disabled and more likely to have complications in relation to alcohol, illicit drugs and additional mental health issues. This contrasts sharply with the historical perception of mental illness being incompatible with learning disability, rendering services inaccessible till the 1980s (Smiley, 2005). Since this time, there is increasing recognition that people with learning disabilities experience both the full spectrum of mental illness and a higher prevalence than the general population (Hardy, Chaplin & Woodward, 2010). One study estimated co-morbidity at 22.2% (Deb, Thomas & Bright, 2001), and another as high as 49.1% (Cooper et al., 2007), whilst schizophrenia has been calculated at three times the average (Doody et al., 1998). The likelihood of people with a learning disability encountering the criminal justice system begins early in life (Hackett et al., 2013), and is frequently complicated by autism spectrum disorder and attention deficit hyperactive disorder (Stinson & Robbins, 2014). Other concerns revolve around the increased likelihood of social deprivation and family breakdown, and the difficulty of this group's location at the boundaries of mental health, forensic and learning disability services (Barron et al., 2004). The study discussed in this paper sought to identify the personal attributes that learning disability nurses perceived as important when working with this group whether in secure conditions or in community settings. Some authors argue such attributes to be innate (Bowring-Lossock, 2006), whilst others suggest that they are subject to successful teaching (Glen, 1998a; 1998b); the paper is further contextualized by concerns around professional lack of compassion (DH, 2012; Francis, 2013) and a subsequent emphasis on values based recruitment (Health Education England 2014; NHS Careers 2013).

Background

Many people with learning disabilities and an offending background in the United Kingdom (UK) are cared for by trained nurses with a discrete learning disability qualification. Internationally, this population are often cared for by mental health nurses with a particular interest in their needs, since the learning disability nursing qualification is rarely recognized outside the UK. A recent volume of collected extended papers, for example, refers to studies from the Netherlands (Polhuis, Kruikemeier, Kamp & Lijten, 2013), Belgium (Pouls & Jeandarme, 2013) and Norway (Sandvik, 2013). One of the fundamental features of learning disability nursing is the emphasis on self-advocacy and human rights, promoting so far as possible that this population experience life in the same way as those without learning disabilities (Wolfensberger, 1983; O'Brien, Poole & Galloway, 1981). This emphasis

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Learning disability, in the context of nursing, remains the descriptive term of choice in the UK, though other terms e.g. intellectual, developmental, cognitive, are prevalent outside of nursing and preferred in other countries.

remains when caring for those who have offended, with empowerment, inclusiveness, being person centred and relationship-focused continuing to be significant (NHS Scotland, 2013). Learning disability nurses also need to be self-aware, emotionally intelligent, have advanced interpersonal skills, actively listen, be compassionate, empathetic and accepting (Scottish Government, 2012). There is evidence that the service setting is influential in the enactment of nursing roles, both in mental health (Mason, Coyle & Lovell, 2008a; Mason, Coyle & Lovell, 2008b) and learning disability settings (Mason & Phipps, 2010), though the tension between promoting service user rights and safeguarding those of others is little explored. There has been an escalating interest in the changing care needs of people with learning disabilities encountering the Criminal Justice System (CJS) over the years. The Reed Report (DH, 1992) advocated a change in direction from custodial sentencing toward rehabilitation in hospital or community settings. This interest increased over subsequent years, with a diversification of nursing roles (Riding, Swann & Swann, 2005; Valuing People Support Team, 2005), a gradual emphasis on supported community placements as well as care in secure facilities (Kingdon, 2009), and consolidation in the publication of the Bradley Report (DH, 2009). The post-Bradley years have witnessed a continuing diversification of community pathways and changing therapeutic approaches (Royal College of Psychiatrists, 2014), including increasing recognition for better access to generic mental health services (Brown et al., 2010). The expansion of learning disability nursing roles and employment locations has also led to concerns about more precise sets of competencies (Department of Health, Social Services & Public Safety, 2014). This role expansion has coincided with a simultaneous reduction in the overall employment of learning disability nurses (Gates, 2011), illustrating the importance of the profession clearly articulating the knowledge, skills and values necessary for successful performance of more specialist roles.

Personal attributes

The fundamentals of a caring relationship in the context of mental health, according to Johansson, Skarsater & Danielson (2007), revolve around respect, closeness and flexibility, and when these are absent or impaired the relationship itself is threatened. These attributes underpin competency performance for learning disability nurses in relation to promoting a healthy lifestyle, addressing underlying health issues, providing positive support and alleviating mental health concerns. The situation is more complicated, however, when the service user group have an offending background, which is invariably compounded by social disadvantage, poverty (RCN, 2014), and additional complexities around substance misuse and personality disorder (Lovell *et al*., 2015). There is a body of knowledge in mental health nursing, which suggests that respect, being non-judgemental (Swinton & Boyd, 2001), genuineness, openness (Scanlon, 2006), self-awareness, honesty (Collins, 2000), maturity and common-sense (Kettles & Robinson, 2000) are regarded as particularly important. Research is more limited in learning disability care, though there is evidence that personal characteristics can be influential when working with service users who can be particularly challenging (Rose, 1993). One study, eliciting the views of carers and service users, identified being caring and nurturing as important (Longo & Scior, 2004), whilst another focused on trust and honesty, reporting that these are difficult to repair once broken down (McVilly *et al*., 2006). A further study looked at service user views within secure services and identified that the qualities least valued related to immaturity, inexperience and poor motivation, whilst those most valued were

helpfulness, humour, honesty, fairness and consistency of approach (Clarkson *et al.*, 2009). These authors also suggested that the surrogate family environment of secure units gives an additional resonance to the role of personal attributes; particularly so, perhaps, when people are placed many miles from home (North West Training & Development Team, 2006).

THE STUDY

Aim

The research question:

- What personal attributes are required to work with people with a learning disability and an offending background?

Design

Studies focusing on aspects of organisational culture or professional roles suggest a qualitative framework (Barbour, 2000), particularly when interaction necessitates openness and the situation, closeness and sensitivity (Seale, 1999). Qualitative data were collected over a 12-month period in 2010/11 in order to elicit views about personal attributes considered necessary for working with people with a learning disability and a background of offending behaviour. A series of semi-structured interviews with learning disability nurses were conducted and a number of focus groups, though the data set utilized for this paper is only the interviews.

Data collection

All secure environments, high, medium and low, were included in the study, as well as community nursing where support was provided to those who had previously been cared for in formal secure facilities. The semi-structured interview schedule was piloted with three community nurses working locally, who had experience of caring for the target population. Questions were generally open, beginning with a general focus on the role before addressing more specifically the personal attributes perceived to be important. The interviews lasted 50-75 minutes (averaging around an hour) and were all conducted in the nurses' working environments.

Participants

Access to participants was facilitated through liaison with a facilitating individual in each clinical area. Participants, all qualified nurses, were purposively selected and contacted via email. A series of individual interviews (n=39) were conducted within participants' employment settings, which comprised high secure (n=7), medium (n=16), low (n=8) and community (n=8). The sample comprised 24 women and 15 men, ranging from 21-60 years old and with 8-21 years of experience in secure care. The medium secure setting also included low secure facilities and many of the nurses in this grouping had considerable experience of both services, hence the high number in this category. All participants were qualified in the learning disability nursing specialism, with several having additional qualifications in mental health (n=7) and general nursing (n=2).

Ethical issues

Ethical approval was obtained from the University Faculty Research Ethics Sub-Committee and the Integrated Research Application System (IRAS). All participants were given written information detailing the aims of the research, the interview process, voluntariness of participation and that responses would be anonymised; all gave written consent prior to involvement. Pseudonyms were assigned to all participants to facilitate anonymity and data handled in compliance with the Data Protection Act 1998.

Data analysis

Burnard's (1991) multi-stage thematic analysis, specifically designed for application to semi-structured open-ended interviews, was utilized, which entailed the creation of a comprehensive, detailed, fairly exhaustive category system. The result was the production of nine sub-categories, which were eventually refined into three discrete themes. The software package MAXqda (Kuckartz, 2001) was employed in the storage and organisation of information; it was also particularly helpful in the tracking of the themes.

Validity and reliability/rigour

Analysis of the data was undertaken by an experienced qualitative researcher with no professional learning disability experience. This analysis was subsequently critically appraised by a researcher with professional experience of nursing people with a learning disability and an offending background who conducted data collection. This was to ascertain legitimacy and fit to the raw data and facilitated the joint construction of a framework of personal attributes which participants regarded as essential to their work.

FINDINGS

Participant quotes are followed by a pseudonym and indication of current working environment: high security (H), medium (M), low (L) and community (C).

A number of personal attributes were described as important for learning disability nurses when working with people with an offending background, and these are categorized in Figure 1.

Insert Figure 1 here

Looking Deeper: "you need to see beyond that and see what else is there"

Justice

Many nurses perceived a sense of justice as important, particularly articulating their recognition of people's personal histories and the factors shaping their development,

but also in contemplating the implications for care practices and relationship development:

> "…most of them have got very deprived backgrounds and severed attachments…parental problems, like mothers and fathers have separated or they have been separated from their mothers, they have been neglected, sometimes the parents have got learning disabilities as well or the parents have abused them" (Millie M).

> "…they're damaged through their life history, a lot of them were damaged from early childhood experiences, usually abusive situations…a lot of dependency issues, fear of rejection, but you've also got to be careful you don't contribute to that damage, coming into organisations like this, so that's why it's important that you have the right staff" (Fiona M).

This emphasis on acknowledging the injustice of past lives was coupled with a tentative recognition of the impact this might have on the propensity for offending behaviour and the importance of helping them to become different people:

> "…they did go on to offend…because of that anger, they wanted other people to feel as they had felt…people that were supposed to protect them, violated them…and that work is to try and get people in touch with that…try to understand that this person's a product of all these dreadful experiences" (Irene H).

Respect

This detailed knowledge of an individual's background fostered a respect for having survived sometimes sustained systemic abuse. Service users had often spent their lives moving through an anonymous system, and nurses were respectful of how they remained resilient to the emotional damage and rejection experienced. Nurses frequently discussed service user lives in terms of a journey, essentially perceiving the job as responding to a build-up of events over many years. As Fiona points out, though, this damage is likely to reveal itself in ways that might be detrimental to establishing a connection:

> "…secure care is usually at the end of a journey which has involved being with foster parents, being in care homes, being in hospitals, institutions and prison, and often that journey is just a journey of physical and emotional abuse" (Robert H).

> "It's important to understand where the patients have come from, why they're presenting as they are…because it's very difficult not to take some of it incredibly personally, because some of the things they say…can be incredibly hurtful" (Fiona M).

Respect, therefore, necessitated the capacity to understand the role of the learning disability and absorb insulting behavior, but also the need to encourage the person to take responsibility. Participants suggested progress was only possible through accepting the consequences of one's actions, supporting people through the system but also negotiating issues such as choice, decision-making and over-protection:

"…yet he still chooses to drink (so) maybe it's not for me to stop him, maybe it's for me to support him through the system. Possibly look at diversion but I can't wrap him in cotton wool and look after him just because he has got a learning disability…he is making choices…I can't impose my will on him" (Stuart C).

Non-judgemental

Many participants identified being non-judgemental as important, partially because of the very nature of working with people whose offending behaviour requires a lot to comprehend, but also because of the therapeutic role of nursing, which necessitates looking more deeply, seeking to explain, even examining oneself:

"…at times you need to have that inner-quality to…not just look at the person for the index offence and be judgemental…you need to see beyond that and see what else is there and see the reasons why that actually occurred in the first place…there but for the grace of god go I" (Julie L).

The alternative to such self-scrutiny, of course, was to figure out a way of engaging without probing too much, adopting a work role that kept service users at a safe distance, behaving professionally but bound by laws, codes, rules, procedures and regulations:

"I think what the staff are very good at here is putting that in a box…whatever crime they've committed, especially the men with the sexual offending against children, they're very good at putting that away" (Laura L).

The most practical strategy for direct engagement witnessed the offending behaviour hanging somewhere in the background, not directly influencing current activity but perhaps affecting risk taking. Veronica reflects on how to avoid investing a situation in denial, communicating with a degree of honesty and openness yet recognizing the weight that offending behaviour tacitly, yet inevitably, brings along:

"…wanting to engage with people…and not judge no matter what people have done, take people at face value at that moment in time, whilst being able to acknowledge there is other stuff going on but without having everything to be around whatever has gone on before" (Veronica L).

Achieving Balance: "you've got to be careful staff don't cross that line"

Pragmatism

Direct relationships were frequently infused with an imperative to introduce clarity, defuse tension and take the heat out of a situation; nurses sought to be pragmatic so as to avoid over-reaction, concentrate on the facts and create circumstances for dialogue, but one was never working with a blank sheet:

"…I said to her 'do you know whether you are being moved?' 'No I won't find out till Wednesday.' I said 'well really there is nothing you can do until Wednesday' and she threatened to cut herself with this staple and then stab a staff with this staple with her blood on and I said 'look if you are upset…I'm willing to talk, but you need to

stop making threats…we will go and sit at the table and talk like adults…I'm not interacting with you while you're threatening people'" (Isobel H).

"…but we have also got be realistic - a person doesn't just come here and leave as a changed person – that person is pretty much developed by the time they get to this service" (Greg L).

Some nurses working in community settings suggested an element of tension with those in secure services around risk; it was not insurmountable, however, and reflected different priorities, but pragmatism was considered important in resolving such encounters:

"…it's about balance, I think, where it gets difficult is things like…that someone can never drink alcohol again – my job is to…use motivational approaches to negotiate with them a position that is okay, give them some sort of trust…there have been times when I've had to back out of it and let the secure service do it all, because they didn't agree with my views" (Garry C).

Tenacity

There was a degree of expectation that many service users could be extremely challenging, sometimes even personally offensive, and responding to this effectively necessitated, not just resilience, but persistence and tenacity. There was the possibility, suggested by Frances, that the more punitive, authoritarian demeanour, favoured by some nurses, could arise in response to such emotional provocation; tenacity encouraged a more considered approach:

"you've got to be careful staff don't cross that line into punitive action, and that's where it's important (to) understand where the women have come from, why they're presenting as they are, because it's very difficult not to take some of it incredibly personally" (Frances M).

Some nurses, though, struggled both with the organisational structure and some of their less progressive colleagues, tenacity being manifest in the insidious way work practices and individual behaviour needed to be tackled:

"I think that to effect change in an organisation like this is kind of parallel to how you expect patients to change…patients here find it difficult to change…it can take a long period of time and chipping away at it…there seems to be a parallel negative…there's a group of people that are toxic, they're quite a powerful group of people" (Irene H).

Nurses talked about the difficulties inherent in successfully building relationships, such as knowing how to work with the emotional complexity, unpredictability and chaotic nature of service user lives. Tenacity was reflected both in the decision to engage and the simultaneous absorption of sometimes abusive behaviours that were subsequently manifest:

"…what we get now with the relationships with staff, a lot of that testing out…trying to reject you before you reject them, so they may be difficult and abusive to you…it's about them feeling safe…how far to test and push and treat you with disrespect before they know…that you're there for them…it is very demanding and draining" (Heather M).

Courage

There was recognition by some nurses that proper engagement with this population necessitated taking risks in relation to emotional investment. This required a conscious choice, a capacity to give information about oneself and encourage the taking of responsibility:

> "…a lot of people are scared of engaging…to engage positively you have to give yourself in a sense, and that can be quite scary even if people don't realize it. It's a lot safer to control a situation…easier to be negative and to punish" (Vanessa L).

A further aspect of courage could be seen in how some participants actively resisted the pressure to retreat into a more disciplinary role, understanding that therapeutic engagement required patience, subtlety and responding thoughtfully. This approach might not always work, though, and sometimes nurses suggested that it took courage to withdraw, analyse in a safe environment, such as supervision, before accepting it:

> "…when a patient is pushing boundaries with you, and they know they are…it can be very easy to become…too authoritarian and sometimes you've got to step back and you've got to think, ok maybe I could've handled that in a bit more of a patient way" (Adele L).

> "…you can try everything to…help him make his own decisions, to give him more and more trust…each time he didn't adhere to what we'd agreed to in his care plan… it made me feel like I was a failure and I talked about this in my supervision…it just wasn't meant to work with that particular individual. So you don't always get things right and it is hard because you think…have I handled the situation wrong" (Heather M).

Connecting: "it is basically sometimes stripping everything else away"

Insight

Nurses were frequently realistic about the difficulties involved in building relationships with service users, demonstrating awareness of the self-defeating nature of normalizing offending behaviour or contributing to the process of denial. There was a need for subtlety of approach sometimes, achieving balance in relationships as well as conveying one's knowledge of what people had done:

> "…you can become desensitised to the offending behaviour (it) almost becomes normal…there is a risk that you can be minimising the behaviour…sometimes it is the process of excusing what they've done and I don't think that helps them…clients often try to blame other people and if you buy into that, it is only building up their own resources in terms of justifying what they did to themselves" (Harry C).

Some participants demonstrated insight into how issues such as learning disability, gender and personal history might inter-relate and contribute towards a degree of service user dependence. There was a suggestion that good relationships were extremely important but there was a constant need to negotiate between the role of the hospital as place of therapy or home:

"…dependency…for some of the women it's probably one of the few stable times in their lives where they're not in an abusive sort of environment…so you can create dependency issues" (Laura M).

Empathy

Nursing people with complicated histories was likely to affect all areas of care, so that issues like reacting to someone's aggressive behaviour could contain multiple possibilities depending on their previous life experience. There might, for example, be a response of bewilderment in the face of physical interventions, though there might equally be other concealed elements in such manifestations of violence:

"...people might find themselves in a situation where they're taken to a separate room with predominantly male staff and put in a face down position …if a person has experienced sexual abuse in childhood…goodness knows what they must be feeling in that situation, if they're not understanding what's happening to them" (Joyce M).

The ability to empathize was clearly regarded as important, particularly through acknowledgement of someone's journey in contributing to the person being cared for, and there was a suggestion that those who were able to do this most effectively might more fully understand the impact of background and the consequent importance of supporting people to change:

"I don't know if it is important but everybody I have met who I think or feel has a really good understanding of the client group seems to have at some point or another disclosed stuff to me about something that has happened in their past" (Veronica L).

Compassion

Nurses often had to figure out how to work best with someone, understand the impact of the learning disability, their social background, and how these contribute to their understanding of the world. The manifestation of compassion sometimes meant unravelling an individual's personal story, the capacity to approach situations from different angles:

"…take it right back to basics and start building again…work with what their level of understanding is to get there, it is basically sometimes stripping anything else away, to find what is there and then building back up" (Jon H).

"You get to know them quite well, you know which are their sore spots, the places that they don't want you to go, it may be something to do with their past history, you know not to avoid it but to go round it in a different way" (Jason L).

Compassion was clearly regarded as central by many participants, but was difficult to properly articulate; subtlety was valued but so was a degree of directness, though it needed tailoring to the circumstances. Humility, sensitivity and the capacity to listen closely all contributed to honest communication, but there was also a suggestion that such qualities were unteachable:

"…a major thing is about being good at listening to people – this comes from experience – it's not something you can be trained to do but you have to be able to listen because there are times when you have to be straight with people, it's not good skirting around the issues" (Jo C).

DISCUSSION

Many participants sought to understand those they nursed as people with complex histories, recognizing not just that their lives were frequently defined by abuse, neglect and rejection, but also that this connected to their offences. They conveyed respect for their capacity for survival, talked of their current detention as sometimes being the safest and healthiest part of their lives. Some were determined to achieve a balanced view, emphasizing the need to accept responsibility as a means of helping people to progress. They wanted to accentuate the contribution of an individual's personal background but resisted excusing offending behaviour, suspecting that this, ultimately, was of little value. Acknowledgement of the significance of someone's childhood reflected the difficulty in society more generally; some saw it as central, others that it was relevant but not inordinately, and others pointed out that some had impoverished backgrounds but didn't offend. It should be acknowledged, though, that the abusive personal history of people with learning disabilities who go on to offend is well documented (Emerson, 2013), and this can be an accurate predictor of future offending (Martorell & Tsakanikos, 2008). The issue underpinned the nursing role, and participants decided on the significance they attached to it by the decision to elevate relative detachment or personal engagement to the fore. A detached position might enable working with people with complex histories, but discourages the closeness necessary for personal disclosure (Reiter *et al.*, 2007).

Recipients of secure learning disability services, until fairly recently, have been severely institutionalized individuals with entrenched aggressive behaviours (Holland, 2004). The last few years, however, have witnessed a greater emphasis on diversion from prison, a re-negotiation of the boundaries between sectors of secure provision and a marked alteration in the composition of those being detained. Service users' primary difficulties are around mental health, personality disorder, substance misuse, homelessness and prison experience, which have been interpreted by many nurses in terms of personal history. The 'toxic' minority of nurses, furthermore, characterized by a reluctance to engage, fearful of taking risks and likely to conceal their emotions in a metaphorical box, at the risk of over-simplification, appear residual from a previous era. The emphasis on service user background provides a way of addressing the profound service change, caring for people who were more street-wise, aware of their rights and experienced in phenomena, such as using drugs and homelessness. Participants' expertise lay in working with the learning disability, other areas provided layers of complexity, and there was an on-going negotiation as to how best develop relationships. Nurses would significantly benefit, though, from learning more about the manifestation of substance misuse in people with a learning disability (Plant *et al.*, 2011), particularly concerns about vulnerability and exploitation (Hardy, Chaplin & Woodward, 2010), and more about the effects of borderline personality disorder, more prevalent the higher the level of security (Hogue *et al.*, 2006) and denied application to this population until quite recently (Alexander *et al.*, 2012). "People may know more than they can articulate" (Zhang et al., 2001: 468), but educational support is required for nurses to fully comprehend how issues of dependency, rejection and emotional disengagement are best addressed.

The three themes, 'looking deeper', 'achieving balance' and 'connecting', together illustrate the importance for many participants of successfully establishing relationships. Competencies, significant in ensuring good communicative strategies and effective decision

making, were insufficient when the knowledge base lacked coherence. Nurses were adjusting to working with people with complicated backgrounds but sought the necessary knowledge to be able to do this well. The employment of personal attributes went some way toward remedying the situation, providing a renewed basis for making a connection with an individual. The connection was where insight, empathy and compassion facilitate real progress in relationship building. The process of connecting, however, depended on the pre-requisite of looking more deeply at the person, understanding how a sense of justice interacted with the need to be respectful, regardless of provocation, and refrain from judgement. This interpretation by nurses, enabled particularly by consideration of personal history, provided the basis for a balanced view wherein pragmatism, tenacity and courage facilitated emotional engagement, acknowledging one's own errors and helping the person mature and accept the consequences of their decisions. Nurses appeared to be struggling with a vision to accommodate vicissitudes brought about by service user changes, perhaps similar to the transition from custodial to recovery model in mental health (Timmins, 2010).

The need to work across disciplines around effective ways of meeting the needs of people with a learning disability and an offending background has been identified as an imperative (DH, 2010), yet mainstream services remain problematic (Brown et al., 2010) and specialist support continues to be advocated (Chaplin, 2009). An emphasis on personal attributes might constitute a mechanism for facilitating inter-disciplinary working, providing a means of addressing that thorny area of values-based recruitment. The field of dementia nursing, for example, where cognitive impairment is also an issue, emphasises personal attributes with regard to promoting decision-making, advocating for patient rights, empathy, compassion (Tsarouch et al., 2011), empowerment, respect, and being non-judgemental (Smythe et al., 2015). The critical element, however, which consolidates such values and attributes in the care of individuals with complex histories, difficulties around intellectual and social functioning, and who have encountered the criminal justice system, concerns the relationship with the service user. The consequences for learning disability nurse education revolve around better understanding of the changing knowledge base underpinning future practice. There is a need for enhanced knowledge, not only around mental illness, substance misuse and borderline personality disorder, but also in relation to their interaction with learning disability and the subsequent manifestation of offending behaviour. This knowledge needs to be informed by research findings, so that specific competencies and nursing approaches are developed which are practicable and evidence based. Learning disability nursing has always benefited from the contribution of mental health nurses, particularly in the care of this population, characterized primarily by being male, young and having a mild learning disability (Lindsay et al., 2010). The majority of participants were learning disability nurses, though there were several mental health nurses and some with both qualifications. This suggests that mental health nurses have much to offer this population, with the expansion in forensic nursing roles in some areas specifically valuing those with experience in both specialties (Scottish Government, 2015). The similar value base of the two professions, revolving around inclusion and human rights, suggests a shared initial approach, but where mental health nursing might be particularly valuable, according to the evidence in this study, relates to the therapeutic use of self (McCourt, 1999) and the emphasis on a self-directed life, which is meaningful and satisfying (Nursing & Midwifery Council, 2015). These areas, along with mental health nursing's emphasis on authenticity (Scanlon, 2006), would appear to be particularly pertinent in supporting this population to understand their own personal history, yet also seek to take responsibility for their actions and lead fulfilling lives.

Limitations

The research was restricted to a relatively small number of participants, though reasonable for a qualitative study where the emphasis is on depth, and representative of all levels of security. Nevertheless, it is not possible to generalise the findings to all secure provision for this population.

CONCLUSION

Learning disability nursing in relation to caring for those with an offending background continues to develop to reflect the changing circumstances of care. Service users are presenting new challenges and nurses continue to figure out ways of relating and supporting them to take responsibility and become better people. Many different sorts of personal attributes can contribute to successful relationship-building, but the groupings described in this paper might be of value in explaining the process by which these complicated negotiations take place. Approaches to education and research need to respond effectively, focusing more clearly on relationship development when contextualized by lives blighted by the issues described. Learning disability nurses require the values and rights-orientated underpinning to their work, but are most successful in developing strong relationships with this changing service user group when adopting a more considered, reflective approach where certain attributes are acknowledged as more effective than others.

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