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Doctoral Thesis:

The Process of Change in Non-Residential Therapeutic Communities

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Word Counts

	Main Text	**Appendices (including tables, figures and references)**	**Total**
Thesis abstract	285	-	285
Literature Review	7,990	4,689	12,679
Research paper	7,959	3,604	11,563
Critical Appraisal	3,796	477	4,273
Ethics Section	2,792	2,386	5,178
Total	22,822	11,156	33,978

Abstract

Staff working with individuals with a diagnosis of personality disorder may experience difficulties within this work (Cleary, Siegfried & Walter, 2002; Fraser & Gallop, 1993). This may impact on service users' experiences of mental health care. Thus, understanding more about the experience of this work may help improve staff's experiences and provision of health care for service users. Correspondingly, a meta-synthesis exploring staff's experiences was conducted using guidelines outlined by Noblit and Hare (1988). From the analysis, four themes were developed: the value of caring; the paradigm of caring; the need for containment; us and them. An overarching theme of moving between extremes was also established. The meta-synthesis highlighted the dynamic nature of this work and difficult experiences in providing care.

The research paper explored the process of change in non-residential therapeutic communities using grounded theory methodology. Eleven participants were interviewed and shared their perception of the process within the therapeutic community. A model was developed which highlighted a difficult process of joining the group, which required commitment to continue. As group members began to feel more comfortable they learnt how to talk within the group and used this to create a safe place. Group members integrated into the group and took on the identity of a group member, through which a reciprocal process was described where individuals used the group for themselves and acted as the therapeutic input for others through challenging, offering advice and sharing their own experiences. This enabled individuals to develop an increased understanding of their own difficulties and utilise the safety of the group to initiate change.

Finally, the critical appraisal considered themes of invisibility and marginalisation apparent across the experience of conducting the literature review and research paper.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from August 2013 to May 2014.

The work presented here is the author's own, expect where due reference is made. The work has not been submitted for the award of a higher degree elsewhere

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Date:

Contents Page

Section Three: Critical Appraisal

Section Four: Ethics Documents

Section One: Literature Review

Clinicians' experiences of working with individuals with a diagnosis of personality disorder: A qualitative meta-synthesis

Word Count: 7,990

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Abstract

Background: Clinicians working with individuals with a diagnosis of personality disorder may have negative attitudes and experiences of this work. This may impact on the experiences of care for service users. Understanding more about this work may help improve service users' care. *Aims:* The aim of the meta-synthesis was to explore the experiences of working with individuals with a personality disorder diagnosis across professions and clinical environments. *Method:* A meta-synthesis of relevant studies was completed following the procedure outlined by Noblit and Hare (1988). *Results:* Four themes were developed: the value of caring; the paradox of caring; the need for containment; us and them. An overarching theme of moving between extremes was also explored. *Conclusions:* Clinicians' experiences of this work were described as shifting between rewarding and challenging and this impacted on the care that service users received. When clinicians remained optimistic about care outcomes they were more able to remain engaged in therapeutic relationships. The team and other resources were key in containing clinicians' experiences. *Declaration of Interests:* None

Keywords

Introduction

Individuals who present to services exhibiting self-harming behaviours, difficulty managing

emotions and interpersonal difficulties may receive a diagnosis of personality disorder

(American Psychiatric Association [APA], 2000). There are 11 personality disorder

categories with Borderline Personality Disorder (BPD) the most common. It has been

estimated that 10% of the UK population meet the diagnostic criteria for a personality

disorder (Alwin et al., 2006). Yet, extensive debates exist around the validity of the construct

(Lewis & Appleby, 1988; Pickersgill, 2013). The clinical utility of personality disorder has

been contested due to the reliability of clinical judgement, high levels of diagnostic co-

morbidity (Alwin et al., 2006), and lack of agreement in the aetiology of the presentation

(Fonagy & Bateman, 2008).

Descriptions have highlighted the construct as being distinct from Axis I diagnostic

categories (Ruocco, 2005). This led to debates around whether personality disorders should

fit within mental health services, with the dominant medical model of mental distress not

accounting for the presentation (Kendell, 2002). Along with these debates historically were

narratives around un-treatability. Pickersgill (2013) argues that a stance of treatment nihilism

may lead to individuals receiving a lower level of care. Individuals with these diagnoses may

be prioritised lower than individuals with other diagnoses and excluded from some services

(National Institute for Mental Health in England [NIMHE], 2003). Thus, these continued

narratives may increase the stigma felt by service users (Pidd & Feigenbaum, 2007).

Despite ongoing debates, individuals are still presenting to services and receiving

diagnoses of personality disorder. Individuals with these diagnoses are regular users of

inpatient and community services (Ansell, Sanislow, McGlashan & Grilo, 2007) and have

been described as "revolving door" clients due to the frequency of service use (NIHME,

2003). Since 2003 there has been an increasing movement to recognise the needs of these

individuals, leading to the development of more specialist personality disorder services and specialist psychotherapy provision. The recruitment of service users into expert by experience, or service user consultant roles, represents an attempt to improve the development of services, incorporating the perspectives of service users (D'sa & Rigby, 2011; Lamph & Hickey, 2012).

Yet, a level of stigma still exists towards individuals with a diagnosis of personality disorder. Aviram, Brodsky and Stanley (2006) hypothesise that staff may distance themselves from stigmatised clients thus initiating feelings of rejection in the client which may increase behaviours deemed to be challenging. Developing a supportive relationship may then be more difficult. Behaviours that challenge may develop iatrogenically, meaning that interactions with professionals could influence the behaviours of service users (Dawson, 1988). Resultantly, research has explored the attitude of mental health professionals towards working with individuals with these diagnoses.

Working with individuals with a diagnosis of personality disorder has been described as challenging and difficult (Fraser & Gallop, 1993). Cleary, Siegfried and Walter (2002) explored mental health staff's attitudes towards this work. The results indicated that 84% of 229 staff members felt it was more challenging than working with individuals with different diagnostic labels. James and Cowman (2007) found a similar response in their study, alongside a view that the care given was inadequate. Deans and Meocevic (2006) explored nurses' perceptions of individuals with a personality disorder diagnosis which indicated that 89% of nurses viewed these individuals as manipulative and 51% thought clients would emotionally blackmail staff. Further, around half of the participants indicated that they were unsure about how to care for individuals with a diagnosis of personality disorder.

Fraser and Gallop (1993) explored mental health nurses' responses to individuals with personality disorder diagnoses. The results indicated that responses to individuals with a

diagnosis of personality disorder were more negative and demonstrated less empathy compared to reactions to individuals with a mental illness diagnosis. Furthermore, Markham (2003) explored mental health staff's beliefs around dangerousness and optimism. The results demonstrated that nurses would be more socially distant to individuals with a diagnosis of personality disorder, who were deemed more dangerous and staff were less optimistic about their recovery. It was concluded that the negative attitudes towards personality disorder could impact on the engagement of staff. Studies into the experience of service users highlighted a perspective that staff were negating and disrespectful (Horn, Johnstone & Brooke, 2007; Langley & Klopper, 2005; Rogers & Dunne, 2011). Service users articulated the challenge in establishing trusting relationships with staff (Langley & Klopper, 2005). However, the quintessential element of mental health care is conceptualised as the therapeutic relationship (Martin, Garske & Davis, 2000).

Consequently, there has been increasing interest in understanding the experiences of staff in this work. The majority of research has used quantitative methods to measure attitudes. Whilst these studies provide an understanding of attitudes, they lack a more in-depth consideration of the dynamic nature of the work. More recently, researchers have utilised qualitative methodology to explore staff's experience of working with clients with a personality disorder diagnosis. By developing a thorough understanding of this work, experiences may be improved, burnout may be reduced and the care provided to service users may be improved.

Research has explored staff's experiences across professional backgrounds and different environments. Yet, there has not been a consideration of the common themes that transcend role or environment. Accordingly, the aim of the current meta-synthesis is to gain a richer understanding of the lived experience of mental health professionals working with individuals conceptualised as meeting the criteria for a personality disorder diagnosis.

Method

Knowledge synthesis is a way of amalgamating relevant studies of an area of interest and can help in understanding multifaceted evidence (Kastner et al., 2012). Compared with other methods which summarise findings across studies, meta-syntheses reinterpret qualitative results to develop a higher level of understanding (Sandelowski, Docherty & Emden, 1997). The researcher chose to utilise the meta-synthesis method outlined by Noblit and Hare (1988) as it provides guidance for the whole process and aims to develop new concepts arising from the original studies.

Search Strategy

A mind map was created to identify terminology for the search strategy (Shaw, 2012). The thesaurus within the PsycINFO database was also consulted. The search was conducted across the PsycINFO, CINAHL, Academic Search complete and Social Care Online databases to represent different professional fields; it included all dates and was restricted to peer-reviewed journals. The following search terms were entered: "personality disorder" AND (view* OR perspective* OR opinion* OR attitude* OR experience* OR understanding* OR response* OR perception*) AND (staff* OR clinician* OR nurs* OR psychologist* OR psychiatri* OR occupational therapist* OR social worker* OR mental health worker* OR therapist* OR psychotherapist* OR counsel* OR profession*) AND (thematic* OR narrative* OR interpretative* OR interview* OR phenomenol* OR grounded theor* OR qualitative OR ethno* OR hermeneutic* OR heuristic* OR lived experience* OR content analysis OR constant comparative method OR discourse analysis OR focus group* OR interview*). Figure 1 details the search strategy.

Insert figure 1 here

The initial search identified 1,431 papers. The title and abstract of each paper was read to identify if it appeared relevant to the aim of the meta-synthesis. Following this stage, there were 126 papers remaining after duplicates were removed. These papers were reviewed in full and were included if they met the following criteria: published in English, used qualitative methodology and explored staff's experiences of working with individuals conceptualised as meeting the diagnostic criteria for personality disorder. Papers were excluded if: they explored a specific therapeutic approach; they exclusively focused on self-harm; they used quantitative methodology; they included viewpoints of service users not reported separately or they focused on a specific construct such as trust in the relationship. Following the application of these criteria, 13 papers remained. The references of these papers were examined to identify any further papers meeting the criteria. This found no additional papers; thus 13 papers were included in the synthesis. Table 1 summarises the papers.

Insert table 1 here

The papers included studies across different professions including six interviewing nurses, three interviewing members of a multi-disciplinary team (MDT) and one each interviewing psychologists, counsellors, case managers and service providers. The studies incorporated perspectives from different countries: six from the UK, two from Ireland and one paper each from Australia, Sweden, America, New Zealand and Taiwan. The studies represented different environments including forensic units, inpatient settings and community settings.

Critiquing the Studies

The degree to which quality appraisal adds value to the meta-synthesis continues to be contested (Shaw, 2012; Spencer & Ritchie, 2012). Noblit and Hare (1988) posit that it is not a necessary part of the synthesising process. Yet, other perspectives highlight that a better quality meta-synthesis may be produced with better quality studies (Atkins et al, 2008). Within this paper, quality appraisal was utilised to understand the strengths and weaknesses of the studies. No paper was excluded on the basis of this appraisal. This is because firstly, it is unclear what score would indicate that a study should be excluded and secondly, due to word limits within journals, a low score may suggest that information was omitted rather than it being indicative of a fundamental flaw.

Each paper was reviewed using the questions from the Critical Appraisal Skills Programme (Critical Appraisal Skills Programme [CASP], 2010). This method was chosen to provide a structured process to consider the strengths and weaknesses. A score was allocated for each question: 1 if there was no evidence that the question had been considered; 2 if some evidence was provided; 3 if the question was fully answered. A number of the CASP evaluations were scored independently by the researcher's peers to ensure a consensus in the score given. Table 2 provides a summary of the scores.

Insert table 2 here

Reflexivity

The researcher is a Trainee Clinical Psychologist with experience of working with individuals with a diagnosis of personality disorder within an MDT. It is recognised that this could influence the researcher's interpretations of the original studies. With this in mind, the researcher kept a reflective diary detailing the analysis and process of reflection. For

example, the researcher's experience of working with this client group was in contrast to some of the narratives described within the studies. It was considered whether this had led to the researcher over emphasising positive narratives so the coding and analysis was rechecked. Furthermore, the analysis was conducted under the supervision of a researcher with experience in conducting and meta-synthesising qualitative research.

Synthesis

The researcher followed guidance on synthesising qualitative studies detailed by Noblit and Hare (1988). Each paper was read several times to become conversant with the original participants' accounts and the original authors' interpretations. Using the language in the original studies, key themes from each study were written on separate post-it notes. The post-it notes included themes from the experience of the participants and interpretations of the original authors. Starting with the post-it notes from the earliest study, the themes and ideas from each study were compared to highlight similarities and differences across all the studies. Similar themes and ideas from across the studies were grouped together into theme piles. As more themes were synthesised these were checked to ensure the constructs they represented remained similar and more theme piles were created if necessary. The same procedure was conducted with the theme piles to create groups of ideas that were similar and from these final themes began to be developed. As a result third order constructs of the original authors' interpretations were created. These are reported thematically.

Results

Following the analysis, four themes were developed: the value of caring; the paradox of caring; the need for containment; and us and them. An overarching theme of 'moving between extremes' was highlighted; this idea was described across all themes.

Moving Between Extremes

This narrative incorporated an understanding that clinicians' experiences when working with individuals with a personality disorder diagnosis were "oscillating between extremes" (Millar, Gillanders & Saleem, 2012, p.118). Service users' behaviours also shifted between poles which left staff feeling uncertain in their skills. Clinicians' experiences fluctuated from "honeymoon to chaos" (Ma, Shih, Hsiao, Shih & Hayter, 2009, p.444) with emotions oscillating between "compassion and anger" (O'Brien & Flote, 1995, p. 142). When clinicians perceived service users to be settled, there was an expectation that this would change: "you may be able to see and measure progress over a number of weeks and then overnight it's all gone" (Woollaston & Hixenbaugh, 2008, p. 706). This oscillation spans across the four themes: as one viewpoint was described, the other perspective was also articulated.

Theme 1: The Value of Caring

Incorporated within 'the value of caring' were narratives of treatability of individuals meeting this diagnostic label. This theme was contributed to across all 13 papers. Clinicians' perspectives around the potential for change impacted on the level of engagement with service users and their experiences of this work.

Working with this client group was complex and difficult, though this helped clinicians enjoy the challenge and provided "a sense of reward" (Millar et al., 2012, p. 112). The challenge was a real bonus and in contrast to other work, this was "never boring" (Crawford, Adedeji, Prince & Rutter, 2010, p. 200). This led to a "high level of satisfaction" (Risq, 2012, p. 42). As seen in the overarching theme, clinicians' experiences could shift between rewarding and challenging. Clinicians articulated the importance of engaging with service users on a genuine and human level seen through feelings of "fondness and protection" (Kurtz & Turner, 2007, p. 428). Empathy helped clinicians focus on the needs of

the service users: "If I'd been through what she had been through I imagine that I would be just as suicidal" (O'Brien & Flote, 1997, p. 140). Indeed, taking an empathic and compassionate approach was key in engaging service users: "You can't help but have a human reaction to their distress" (Millar et al, 2012, p. 119).

This empathic attitude allowed clinicians to consider not just behaviours but an understanding of the psychological context and a holistic understanding of the underlying message behind an action: "the self-harming is a means of communication to express their anxieties" (Commons-Treloar, 2009, p. 32). Clinicians considered clients' early life experiences and experience of relationships: "there would be a history of abuse in some form in childhood" (O'Connell & Dowling, 2013, p.29). This allowed staff to understand why these difficulties were present and approach their work with more compassion. Understanding the client's behaviour impacted on clinicians engaging more with the client and provided more optimism towards change: "you gain knowledge and change your outlook" (Stroud & Parsons, 2012, p. 248).

Clinicians articulated "hope that clients...can change" (Millar et al, 2012, p. 118). A successful outcome was described in different ways across environments. Staff in a forensic unit spoke about service users opening up as real progress: "he...disclosed to the group what he did...it actually felt like you'd got somewhere with him" (Kurtz & Turner, 2012, p. 429). Seeing progress was a positive and satisfying experience for staff which led to more determination: "if you put in the work and encourage the client to do likewise, you will see results" (O'Connell & Dowling, 2013, p.29). A belief in change led to clinicians developing approaches to care based on the needs of the client: "I tried to learn what was on her mind in addition to providing routine care for her... It worked" (Ma et al, 2009, p. 444).

However, within the narratives were descriptions around the inadequacy of staff, services and the system. This was seen as a group of people who needed care: "somebody

needs to help these people" (Risq, 2012, p.45). Yet, the "financial and time constraints"

(Millar et al, 2012, p. 121) of the system impacted on the ability to provide an effective

service. There was an understanding that long term input was needed, yet services were not

set up for this. Papers that contributed to this narrative were mainly from the UK, though

similar descriptions were found across the papers from Sweden and New Zealand. Clinicians

began to feel guilty about what they could offer and whether services could be counter-

productive: "Are you going to do them any good? And are we really just re-traumatising

these people again?" (Risq, 2012, p. 43). Staff who were most positive were those within a

forensic unit where long-term input was required, but not for therapeutic reasons. Services

were seen to not be working together, but instead referring service users on: "They are

inpatients because we lack adequate resources in the outpatient organization" (Bergman &

Eckerdal, 2000, p. 249).

Behind this was an understanding that there was a lack of knowledge, understanding

and resources within teams: "borderline personality disorder is not one of my fortes" (Stroud

& Parsons, 2012, p. 246). Staff found that without a shared framework around the

difficulties, it was hard to develop understanding. This led to staff describing behaviour in a

more pejorative way with less compassion and empathy. Indeed, it increased the feelings of

uncertainty about how to provide effective care: "Whether to be lenient with her or try to

adhere to the guidelines that had been set in the contracts" (O'Brien & Flote, 1997).

Narratives were also present around the inadequacy of society in understanding the

needs of people with a diagnosis of personality disorder. Again, these papers were largely

representative of participants within the UK. It was hypothesised that this may play a role in

perpetuating negative environments for service users. Society was considered to not listen to

the needs of these clients, nor take any responsibility for them: "He was an ideal client for

NHS long-term therapy. And I thought, if he's not-who is actually? Who are they going to

take? I mean, somebody should accept these people...assuming we are going to be a caring society" (Risq, 2012, p. 45). This was extended to the media maintaining negative stereotypes: "I absolutely hate the media...extraordinarily destructive" (Kurtz & Turner, 2007, p. 426). Another participant described how stigma affected clinical judgements: "It is hard for the patient to be given an objective assessment" (Commons-Treloar, 2009, p. 32).

Clinicians spoke about feeling personally inadequate. This fluctuated across situations and was present when relationships with service users were more difficult. Clinicians "expressed doubts" (Nehls, 2000, p. 14) about their skills: "I trained to be a nurse to actually make people better...I have to realise that, you know, I'm flawed too" (Woollaston & Hixenbaugh, 2008, p. 706). Feeling inadequate was linked to the complexity of the service users. Clinicians went into interactions feeling that it was a "no-win contract" (Risq, 2012, p. 39) and that what they could offer is "never going to be enough" (Risq, 2012, p. 39). For individuals who worked in non-specialist services, knowing there were individuals specifically trained to work with this client group increased those feelings of personal inadequacy.

These societal narratives and the personal inadequacy felt by staff led to feelings that change could not happen. This was linked to a lack of resources and knowledge, but also to the characteristics of service users that make change unlikely. Clinicians felt that there was "little advantage in the existing way of treating BPD" (Bergman & Eckerdal, 2000, p. 249). Staff wondered if they were "doing anything useful" (O'Brien & Flote, 1997, p. 140) and this led to feelings of frustration that staff were unable to help: "I don't really like working with them because I'm not able to see a result for my effort" (Woollaston & Hixenbaugh, 2008, p. 706).

This acceptance that treatment may not help led some to lose hope in change: "there'll be clients that don't respond and those that will die" (Crawford et al, 2010, p. 199) and impacted on the way staff interacted with service users:

> Caring for them just wastes time and money. I didn't want to understand what they were thinking. Our efforts would not help them change their personalities or disease at all. The only thing I could do was to handle their acting-out behaviour with routine care. (Ma et al., 2009, p. 444)

Staff's engagement with service users changed based on their expectations. Some thought it was a "waste of clinical time" (Commons-Treloar, 2009, p.32) if nothing would work. Negative expectations led to only basic needs being met and to staff being more concerned with ensuring boundaries were maintained than trying to engage service users therapeutically.

Theme 2: The Paradox of Caring

This theme highlighted the importance of the relationship with service users; yet, this relationship led to a tension that impacted on the way staff approached their work. A good relationship was required to help service users progress, yet there was fear that engaging fully would make their working life less safe. The difficulties experienced by clients in relating to others and maintaining boundaries underlined the staff's fears. Staff wanted to relate, but remained fearful of becoming too involved. All of the papers contributed to this theme.

The therapeutic relationship was seen as a vehicle for consistency by using boundaries for the benefit of the service user: "being genuine, validating the client and the distress or difficulty" (Stroud & Parsons, 2012, p. 248). Having a supportive relationship allowed clinicians to set boundaries and have a therapeutic space; without this, boundaries were seen as "counter to connecting" (Nehls, 2000, p. 16). Lack of communication made it more difficult to develop a compassionate understanding as there was limited context to

contemplate. Trust was considered to be fundamental in building up the relationship: "the main thing is to get the trust and that can take ages" (O'Connell & Dowling, 2013, p. 30).

Relationship dilemmas impacted on day to day interactions with service users. Clinicians were concerned with maintaining the relationship but having a "humane detachment" (Crawford et al, 2010, p. 201) or showing "the appropriate level of concern" (Nehls, 2000, p. 14) for the service user and the appropriate level of engagement. Other worries were conceptualised as "moral dilemmas" (O'Brien & Flote, 1997, p. 142), in terms of expressing genuine care but then acting counter to this, such as carrying out observations. This left clinicians unsure about how to interact and about their own boundaries: "I think it's probably a fear of developing into...more willing to cross the boundaries, being more of a friendship role" (Nehls, 2000, p. 15). Staff were aware of the importance of boundaries but sometimes it was seen as easier to "give in rather than face a confrontation" (O'Brien & Flote, 1997, p. 141).

Indeed, staff spoke about the anxiety of engaging in these relationships. The interactions of service users was overwhelming and felt like staff were being "sucked dry, emotionally swamped, or psychologically sapped" (Risq, 2012, p. 40). Distance within the relationship was safer but this was "antithetical to the therapeutic" necessity of the relationship (O'Brien & Flote, 1997, p. 142). Staff felt "uncomfortable" (Woollaston & Hixenbaugh, 2008, p. 706) if it seemed like the service user had become too attached to the relationship and so developing a "superficial" (Ma et al., 2009, p. 445) relationship was a conscious action to protect themselves.

Staff also protected themselves by consciously managing boundaries. This was a way of staff demonstrating that they had "exerted" (Kurtz & Turner, 2007, p. 430) control over the service users. This was done when it was perceived that service users were not engaging appropriately with staff. Indeed, behaviours deemed appropriate for other service users like

phones calls or requests about "small things" (Nehls, 2000, p.15) were conceptualised as crossing boundaries. Boundaries were seen as protection as opposed to being for the benefit of the service user: "A lot of the staff have got [work] phones…there's no way [they will have my direct number]" (Stroud & Parsons, 2012, p. 247). This allowed staff to "maintain a psychological distance" (Risq, 2012, p. 39). However, this obstructed the relationships and prevented individuals from being supported to take positive risks. Staff had developed ways of protecting themselves from the emotional impact of the work by "suppressing their own emotions" (Stroud & Parsons, 2012, p.247). The avoidance approach appeared to be favoured with staff becoming "immune" to the impact of service users' behaviours (Woollaston & Hixenbaugh, 2012, p. 707) and the need to "develop a barrier" (O'Brien & Flote, 1997, p. 143) against witnessing distressing behaviour.

        Clinicians also described going into survival mode to perceived threats by the system. Staff felt they were held responsible for their clients: "you don't always make the best decisions for her because you are worrying about yourself" (O'Brien & Flote, 1997, p. 143). This led to a feeling of "watching your back" (Woollaston & Hixenbaugh, 2012, p. 707) and to staff documenting all their interactions. They felt under threat from people not understanding the work and felt anxious about anything going wrong: "nothing else just risk and litigation. A big part of it, we've got to cover ourselves" (Stroud & Parsons, 2012, p. 249). This was largely reflective of the papers from the UK. Staff also utilised the team and feeling part of the team helped to minimise the perceived threats as described in the next theme.

Theme 3: Need for Containment

        This theme conceptualises the importance of containing structures to help staff. Participants described the team as an essential source of support in validating actions of individual workers and containing emotions. However, conflict in the team acted to intensify

some of the negative experiences. This was an inherent part of this work and was linked to a

lack of understanding about personality disorder and the experience of clients "staff splitting

all the time" (McGrath & Dowling, 2012, p.5). This theme was contributed to by all 13

papers.

     The need for a support system was paramount in helping staff deal with their daily

role. Compared with working with individuals with a diagnosis of mental illness, clinicians

felt that more support was needed. Staff support was an effective coping strategy in dealing

with emotions that arose: "after expressing my emotions, my strength returns" (Ma et al,

2009, p. 445). Professionals were able to check out and validate their actions, which made

the experience of work more positive. For this support to be effective it was important for

there to be an "open, honest forum" (Kurtz & Turner, 2007, p. 430) and communication was

key. A coherent staff team was seen as important, otherwise service users would have

"unsatisfactory care experiences" (Ma et al, 2009, p. 445). This support helped professionals

care better for service users by feeling looked after: "I look after my staff and then they look

after the clients. But with the clients being so chaotic and that I'm expecting them to work is

so demanding, something's got to be solid, and that's me (Crawford et al, 2010, p. 202)"

     The staff team were instrumental in developing skills through sharing advice and

resources. Experienced staff sharing positive care experiences was valuable in providing

different ways of caring. Interactions with team members and formal training led to a

common philosophy and framework which enabled a more consistent outlook: "if we start to

talk we may agree about many things" (Bergman & Eckerdal, 2000, p. 250)

     A MDT was seen as a positive resource that "promoted high levels of collaborative

care" (Kurtz & Turner, 2007, p. 430). Although staff recognised the need for clear

leadership, staff also felt the team worked best when the opinions of all staff were validated

and accepted. Indeed, having a MDT provided a holistic understanding and care package for

service users through discussing "best avenues for treatment" (Stroud & Parsons, 2012, p. 248). Importantly for staff, being part of a team led to a sense of belonging and this was important for staff wellbeing.

However, staff also described the difficulties that arose when the team was not working together consistently. Having different professionals highlighted different ways of understanding clients' presentations which impacted on "ambivalence concerning choice of method" (Bergman & Eckerdal, 2000, p. 248). Debates existed within teams around the legitimacy of the diagnosis and the right to treatment. When different approaches were apparent, communication was seen as really important for staff's methods to be transparent. Yet this was not always the case.

Indeed, staff articulated the "devastating impact of isolation" (Kurtz & Turner, 2007, p. 426) that occurred with differing team opinions. Staff felt isolated without a safe team: "you're kind of left on your own with somebody, and you don't have a team to consult, you don't have the support" (Risq, 2012, p. 44). Conflict within teams was a stable part of some environments as staff were sitting in "camps" (Woollaston & Hixenbaugh, 2008, p. 706). Conflicts existed over the best way of managing clients, risk and boundaries between staff and service users. When a staff team had different ideas or understanding of the best way to proceed, both sides were criticized and this led to inconsistent care.

Whilst these team dynamics were detrimental to staff wellbeing and the care that service users receive, clinicians found it "difficult to confront" (McGrath & Dowling, 2012, p. 6) colleagues. Clinicians were worried about losing support and causing more conflict: "we did challenge each other... it probably was only when it felt safe rather than when it was needed" (Kurtz & Turner, 2007, p. 429). There was a worry that it would be perceived as staff members attacking each other. Staff appeared defensive in their actions and became

distrustful of others, leading to limited communication. For some staff, conflict within the team was more difficult to manage than conflict with service users.

Theme 4: Us and Them

This theme incorporated narratives consistent with an "us and them" (Millar et al, 2009, p. 115) perspective. It highlighted the negative descriptions of service users and the distance placed between individuals with a diagnosis and those without. This provided protection for staff feeling different from and distancing themselves from the vulnerabilities associated with the diagnoses. However, staff began to see these behaviours as being on a continuum and this created a tension between wanting to distance themselves from the suffering and vulnerability and seeing aspects of themselves within the service users. All of the papers except O'Connell & Dowling (2013) contributed to this theme.

Across the papers were portrayals of the negative characteristics given to individuals with a diagnosis of personality disorder. They were described as "burdensome" (Nehls, 2000, p. 15), "manipulative" (Millar et al, 2012, p. 117) and that they "want to be the centre of attention" (Bergman & Eckerdal, 2000, p. 248). These negative descriptions were indicative of the perception that these behaviours were intentional: "I have found people with BPD to be manipulative and I wonder if BPD is just an excuse for bad behaviour and nastiness" (Commons-Treloar, 2009, p. 31). These ideas were often described as if facts; yet, there were few examples of what was indicative of attention seeking: "I have an image of them being quite manipulative and attention seeking and you can never quite be sure with the information" (Millar et al, 2012, p. 117). Unlike the first theme where staff were trying to understand, there was an absence of compassion and empathy in these descriptions.

Yet, when speaking of actual behaviours observed this led to descriptions of the emotional impact of these on staff's wellbeing: "I remember getting out of this meeting and just sort of crying and shaking" (Woollaston & Hixenbaugh, 2008, p. 705). Behaviour like

self-harm, threats and violence were frightening and distressing. When negative descriptions were linked to actual behaviours, staff were able to see this action through an empathic lens by understanding that it was not the "service user personally but the behaviour" that was challenging (McGrath & Dowling, 2012, p.3). Staff saw strong emotions like anxiety, belittlement and anger arising from service users' behaviours and interactions. Indeed, some staff felt traumatised within these relationships: "Our relationship ended without any resolution. When I look back, this experience was traumatic for me." (Ma et al, 2009, p. 445)

Individuals with these diagnoses were described as odd and were seen as the service users that no-one wanted to work with. Descriptions of these clients being "markedly" (Millar et al, 2012, p. 115) different to other clients impacted on the care they received. Clients were denied therapeutic activities based on clinicians' anxieties or the view that there was little point providing anything but basic care. Focussing on the behaviours distracted from focussing on the "emotional or psychological" aspects of an individual's presentation (McGrath & Dowling, 2012, p. 3).

On one hand staff saw these clients as different to other client groups which helped distance "from one's own vulnerability to having personality disorder" (Millar et al, 2012, p. 115). However, staff became aware that difficulties could be seen on a continuum: "I think there are graduations of it and I think in all of us there are fears of abandonment" (Risq, 2012, p. 36). Indeed, they recognised that given similar experiences "anyone would behave in the same way" (Millar et al, 2012, p. 120). There were considerations that some needs consistent with this continuum were being met by staff in pursuing this career: "people that need to work in this area have intense emotional needs themselves" (Crawford et al, 2010, p. 199). Staff identified with some of the traits, particularly when worried about "threat of breakdown or madness" (Kurtz & Turner, 2007, p.427). Working with these individuals raised "personal issues" (O'Brien & Flote, 1997, p.143) which could feel uncomfortable. This work led staff

to develop better insight into themselves but also to become aware of their own vulnerabilities: "I almost get a heightened sense of what humanity is and vulnerability" (Risq, 2012, p.41).

Staff became aware of the emotions present when working with these clients and there was a tendency to locate these within the client. Staff reported an "uncomfortable personal reaction" (Commons-Treloar, 2009, p. 31). The importance of becoming self-aware and practising reflective care to "separate out a patient's problems from their own" (Kurtz &Turner, 2007, p. 427) was highlighted. Indeed, with difficulties in the therapeutic relationship staff wondered whether this was something inherent in the client or other factors in the staff. On occasions, staff were able to use their emotions and reactions to understand the client: "contradictions that the client's carrying is sort of pushed into you and you're feeling….you're beginning to feel what the client feels" (Risq, 2012, p.38).

Clinicians spoke about using resources to manage these difficult dynamics: "I find that I've got to go through a process, a sort of reflection thing in my head" (Stroud & Parsons, 2012, p. 248). It was important for professionals to have a place to debrief and work through the emotions. For some staff, this involved accessing personal therapy, but for the majority the importance of regular and specialist supervision was imperative.

Discussion

The aim of the synthesis was to provide a richer understanding of the experience of clinicians working with individuals meeting the criteria for a personality disorder diagnosis. The synthesis included 13 papers from different professions, environments and countries. From the synthesis four themes were developed: the value of caring; the paradox of caring; the need for containment; and us and them. An overarching theme of moving between extremes was also established.

The clinicians described how their experience could fluctuate between two extremes. This was evident across the four themes and added to the uncertainty experienced. This suggests that interactions between staff and clients are complex and the research reporting negative attitudes of clinicians should be interpreted with this in mind. Moving between extremes could be interpreted as reflecting a process of splitting. This 'splitting' has been described as putting individuals into good and bad categories (Bland & Rossen, 2005). These strong emotional reactions for service users may occur within relationships and can evoke similar feelings and dynamics within staff (Bland & Rossen, 2005; Gabbard, 2001).

Within the 'value of caring' were perspectives on whether mental health care helped individuals with these diagnoses. The participants' narratives were largely reflective of the debates surrounding the diagnosis and its depiction as untreatable (Pickersgill, 2013). However, specialist psychotherapies have been developed specifically for individuals with a diagnosis of personality disorder (Bateman & Fonagy, 2006; Linehan, 1993). A review conducted by Bateman and Fonagy (2000) suggested the effectiveness of some forms of psychotherapy for individuals with a personality disorder diagnosis. Aviram et al. (2006) contend that the interactions of professionals can impact on the behaviour of the service user and the perceived progress they are making. So, it may be important for staff to be aware of the existing evidence of the progress made in the care of individuals with a diagnosis of personality disorder

The results of this meta-synthesis suggest that if staff hold more positive views about change, the care they provide may be improved and positive change be made more likely. The narratives around non-treatability do not just derive from individual clinicians but can be seen as being rooted in deeper systemic stigma present in the media, healthcare organisations and within the curricula of training programmes. Whilst work has attempted to address the stigma within the UK (NIHME, 2003), the original studies reviewed are recent in date and

the views of staff were demonstrative of difficulties in the provision of care. This may be indicative that more work may be required to reduce the stigma and imbalance of care attached to this diagnosis.

The second theme, 'the paradox of caring', is demonstrative of the dilemma of engaging in therapeutic relationships. Staff articulated a wish to engage in a fully collaborative, respectful relationship with service users but there were fears linked to an understanding that individuals with this diagnostic label may have difficulties in interpersonal relationships (APA, 2000). Staff members articulated a need to protect themselves personally and professionally from the perceived consequences of these relationships. Relationships were described as superficial, with a level of detachment. This is corroborated by qualitative research where service users articulated difficulties in engaging in meaningful relationships with staff. Fallon's (2003) results suggested that the best relationships were with members of staff who were honest, communicative and provided clear boundaries. The narratives of participants within this meta-synthesis indicated that there was uncertainty about boundaries and this may add to difficulties in relationships.

Barnicot et al. (2012) undertook a quantitative review looking at the factors related to outcomes in therapy for individuals with a diagnosis of personality disorder, suggesting that an important factor is the therapeutic relationship. Thus, the findings of this meta-synthesis, highlight a paradox for clinical teams. The synthesis suggests that better care is provided when staff are more optimistic and this may impact on how they engage in the relationship. Thus engaging fully in the relationship may maintain optimism and empower the service user. However, alongside this are the fear and strong emotions that arise. This results in a no-win dilemma: either the relationship is superficial and the level of person-centred care is limited or staff members engage more fully but are more likely to experience stress in their work.

Within the third theme, 'need for containment', are perspectives around support that could help reduce the emotions described. Crawford et al. (2000) suggested that a supportive team led to lower levels of stress. The supportive team also allowed for the sharing of information and resources about what helped in their clinical work. Bodner, Cohen-Fridel and Iancu (2011) found that senior staff had more positive attitudes compared with junior staff. The sharing of ideas and experience as a more explicit part of team working may be beneficial in promoting positive narratives of care.

As articulated in the meta-synthesis, when teams were less supportive the difficulties in working with different understandings of the client's presentation were highlighted. This led to disagreements and confusion over the best way to support an individual. The importance of a supportive team is validated by perspectives that working in a multi-disciplinary team is likely to produce better outcomes (Bateman & Tyrer, 2004). The meta-synthesis highlights the importance of building time into a clinician's workload for self-care. Whilst costs may be saved in the short-term in increasing an individual's caseload and removing reflective groups, supervision and training, this meta-synthesis suggests that without these structures staff may experience more burnout and be less effective.

The final theme, 'us and them', highlights the tension between staff distancing themselves from the individuals they are supporting and confronting the vulnerability of human experience. Clinicians may hear traumatic experiences and observe behaviour that is challenging. Distancing themselves from this may serve as a protection against their own vulnerabilities. Servais and Saunders (2007) consider the role of disidentification in conceptualising those with a psychiatric diagnosis as being not normal and seeing the self as normal and not susceptible to mental health problems. This disidentification or 'othering' (MacCallum, 2002) diverts away from seeing personal vulnerability. Ballatt and Campling (2011) posit that some individuals who pursue a helping career may be driven by personal

experiences. They argue that this can be of great benefit through compassion and commitment to the role. However, they hypothesise that if these motivations are not clear this can lead to staff feeling like a 'wounded healer', resulting in burnout. It may be important then for staff to have a reflective space for these issues and the emotions arising through this work to be discussed, particularly at times when progress is hard to identify.

Evident across a number of the themes were some different experiences based on the professional role or working environment. The staff members who provided the most positive narratives around their work were those who worked in a specialist forensic unit (Kurtz & Turner, 2007). It may be that these individuals had made more of a choice to work in specialist services. Staff in other services spoke about not feeling trained and feeling inadequate. An individual may choose to work in a community mental health team to specialise in the care of individuals with a mental illness diagnosis, but find themselves working with individuals with complex needs. This suggests a need to provide training on complex needs for all individuals working in mental health care.

Clinical Implications

The themes developed from the meta-synthesis highlight implications for staff and managers working in services providing care to individuals with a diagnosis of personality disorder. The findings indicate the importance of all staff having adequate training in specific skill sets. For participants in the studies, not having these skills increased the anxiety attached to clinical decision making, the feelings of being inadequate and subsequent negative emotions. Yet, the participants articulated an interest in learning more and having more training on the subject. This would suggest that staff working in these environments should have access to appropriate training, resources and a source of clinical expertise that can be utilised to check clinical decision making. If staff feel more certain in their skills this may increase the hope that service users can benefit from care.

Consideration may be given to developing the role of psychological formulation within teams (Johnstone & Dallos, 2006). The findings of this meta-synthesis suggest that staff were keen to understand the needs behind behaviours but struggled without a framework to follow. The findings also suggest that an increased understanding may contribute to behaviours being described in a less pejorative way and maybe increase the likelihood that staff can engage in meaningful relationships with service users (Aviram et al., 2006). This could help to facilitate a more person-centred approach to care by helping staff to develop an understanding of service users with a personality disorder diagnosis not as a homogenous group but as individuals with a unique set of circumstances and difficulties. Having a multi-disciplinary approach with a thorough assessment process and formulation of the holistic needs of each client may thus help both staff and service users.

Furthermore, the results indicate that supervision is a key part of this work and this should be a fundamental part of working in these services (Bland & Rossen, 2005). Indeed, supervision could be a space that some of the inherent tensions evident within the themes reported here could be explicitly discussed, normalised and worked through. It was not clear in the participants' descriptions whether the emotions that came with this work were validated and discussed explicitly as a normal part of their work and so this may form another recommendation for staff teams to have a space for this to be achieved.

Limitations and Recommendations

The themes developed in this meta-synthesis are three times removed from the lived experience of the original participants, through their data being transcribed, analysed and pooled with other data and the original authors' interpretations before being synthesised with other studies. Thus, the themes and narratives developed within this meta-synthesis progress through the author's own interpretations of the data and it is probable that other researchers may have interpreted certain aspects of the data in different ways.

Yet a strength of the review includes the heterogeneity of the papers. Papers were synthesised across different professions, clinical environments and different national contexts. Indeed, the results draw on the experiences of professionals across a range of different environments, professional training, years of experience and interest in working with this client group and this may have enriched the understanding of working with individuals with a diagnosis of personality disorder.

A number of recommendations for future research are suggested by this review. It may be of benefit to explore what helps staff members have more of an optimistic approach to change and for service users to inform future training. Additionally, there has been some research into service users' experiences of engaging in services (Fallon, 2003; Horn et al., 2006). However a more in depth understanding of their experiences of working with staff members may add another, systemic dimension to the results described here. Research looking at the relationship from both service user and staff member perspectives may help in understanding the dynamics involved. Furthermore, this may provide an understanding of the quintessential aspects of a caring service from the perspective of the service user. It remains unclear how these experiences of working as a professional impact on the experience of being cared for. Research may also focus on the impact of formulation within teams and the impact of staff teams or management where supportive structures are not prioritized. It may also be of benefit to explore the current understanding of stigma and societal influences within this client group.

Conclusion

The themes developed within this meta-synthesis provide a perspective that working with individuals with a diagnosis of personality disorder shifts between poles of experience. Staff articulated that when they remained optimistic about care they were able to remain present within the relationship. However, with less optimism staff were less able to engage

in person-centred care. Dilemmas within the relationship were highlighted along with

narratives around keeping a distance to protect against the vulnerabilities witnessed. Staff

highlighted structures and resources that help contain the emotions that arise through this

work. Resultantly, staff may benefit from a space within their work where these emotions

and experiences could be explored and the impact on working experiences could be reduced.

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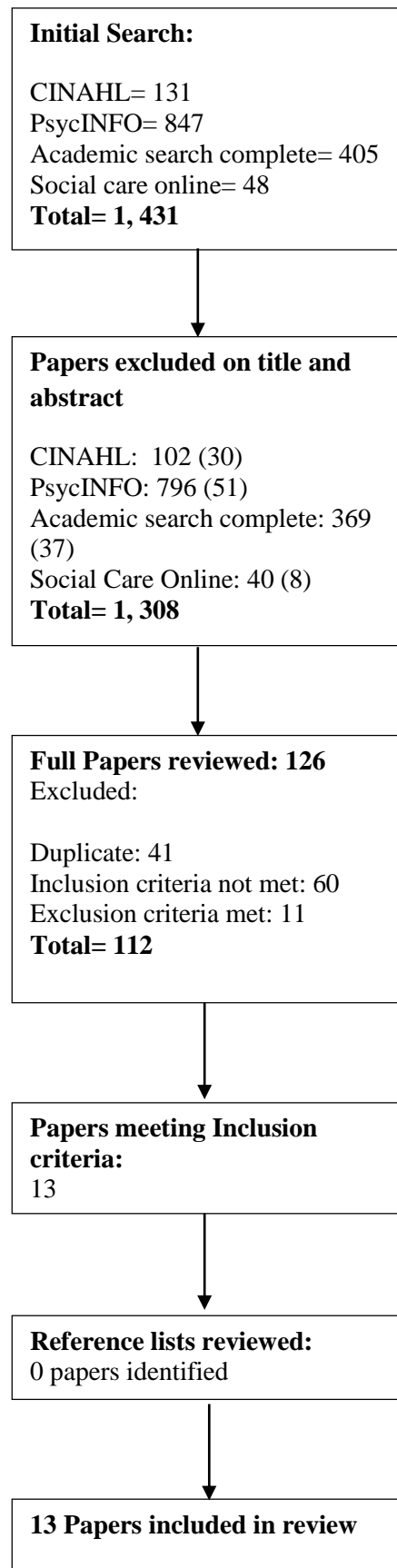 *Mental Health Nursing, 15*, 703-709

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│ Initial Search:                     │
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│ CINAHL= 131                         │
│ PsycINFO= 847                       │
│ Academic search complete= 405       │
│ Social care online= 48              │
│ Total= 1, 431                       │
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│ Papers excluded on title and        │
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│ CINAHL:  102 (30)                   │
│ PsycINFO: 796 (51)                  │
│ Academic search complete: 369       │
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│ Social Care Online: 40 (8)          │
│ Total= 1, 308                       │
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│ Full Papers reviewed: 126           │
│ Excluded:                           │
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│ Duplicate: 41                       │
│ Inclusion criteria not met: 60      │
│ Exclusion criteria met: 11          │
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Figure 1. Search Process

Table 1. Study Characteristics

	Researcher Discipline	Country	Methodology	Sample	Study Aims
O'Brien & Flote, 1997	Nursing	Australia	Phenomenological Approach	6 nurses	To explore the subjective experience of nurses who had cared for a patient with a diagnosis of borderline personality disorder
Bergman & Eckerdal, 2000	Psychology	Sweden	Grounded Theory	29 staff: nurses, physicians, social counsellors and psychologists	To broaden the understanding of what it means to manage individuals with a diagnosis of borderline personality disorder
Nehls, 2000	Nursing	USA	Interpretative Phenomenological Analysis	17 community mental health centre case managers	To examine case management for individuals with a diagnosis of personality disorder as it is practiced and experienced by case managers
Kurtz & Turner, 2007	Psychology	UK	Grounded Theory	13 staff in a personality disorder unit: 6 nurses, 2 psychiatrists, doctor, social worker, psychologist, occupational therapist, probation officer, teacher.	To explore the relationship between stress and job satisfaction and if this work has a negative experience on staff working with individuals with a diagnosis of personality disorder
Woollaston & Hixenburgh, 2008	Psychology	UK	Thematic Analysis	6 nurses	To give nurses a voice and evaluate current theories on the subject of working with personality disorder
Commons-Treloar, 2009	Not Stated	New Zealand	Thematic Analysis	140 health practitioners: nurses, psychologists, social workers, occupational therapists, psychiatrists	To explore the difficulties that may have contributed to the negative interactions reported in the evidence base around working with individuals with a diagnosis of personality disorder
Ma, Shih, Hsiao, Shih & Hayter, 2009	Not stated	Taiwan	Content Analysis	15 mental health nurses	To explore the contributing factors and effects of Taiwan's mental health nurses

					decision making patterns for clients with a diagnosis of borderline personality disorder
Crawford, Adedeji, Price & Rutter, 2010	Not Stated	UK	Thematic Analysis	89 service providers	To explore factors which add to or reduce the risk of burnout and to examine staffs responses to working with individuals with a diagnosis of personality disorder
McGrath & Dowling, 2012	Nursing	Ireland	Thematic Analysis	17 psychiatric nurses	To explore nurses' interactions and empathy towards service users with a diagnosis of borderline personality disorder
Millar, Gillanders & Saleem, 2012	Psychology	UK	Interpretative Phenomenological Analysis	9 trainee psychologists and 12 qualified clinical psychologists	To explore clinical psychologists' experiences and perceptions of working with clients with a diagnosis of borderline personality disorder
Rizq, 2012	Psychology	UK	Interpretative Phenomenological Analysis	5 primary care counsellors	To explore how counsellors experience working with borderline clients and what might be needed as support
Stroud & Parsons, 2012	Psychology	UK	Interpretative Phenomenological Analysis	4 community psychiatric nurses	To gain a fuller understanding of how frontline professionals understand the presentation of borderline personality disorder and how this influences care
O'Connell & Dowling, 2013	Nursing	Ireland	Thematic Analysis	10 community psychiatric nurses	To explore the experiences of community psychiatric nurses caring for clients with Borderline personality disorder

Table 2. CASP ratings

	Research Design	Recruitment strategy	Data Collection	Reflexivity	Ethical Issues	Rigour of analysis	Clarity of findings	Value of research	Total
O'Brien & Flote, 1997	2	2	2	1	2	2	2	2	15
Bergman & Eckerdal, 2000	2	2	3	1	1	3	2	2	16
Nehls, 2000	2	2	2	1	2	2	2	2	15
Kurtz & Turner, 2007	1	2	1	1	1	2	3	2	13
Woollaston & Hixenbaugh, 2008	2	2	2	2	3	2	2	2	17
Commons-Treloar, 2009	1	2	2	1	2	2	2	2	14
Crawford, Adedeji, Price & Rutter, 2010	2	2	2	1	1	1	3	3	15
Ma, Shih, Hsiao, Shih & Hayter, 2009	3	3	2	1	3	2	3	2	19
McGrath & Dowling, 2012	2	2	2	1	2	1	3	3	16
Millar, Gillanders & Saleem, 2012	2	2	3	1	1	3	3	3	18
Rizq, 2012	2	3	3	1	2	2	3	3	19
Stroud & Parsons, 2012	2	3	3	1	3	2	3	3	20
O'Connell & Dowling, 2013	1	2	1	1	2	1	2	2	12

Appendix 1-A

Constructing a theme

Table 1. Constructing a theme

Theme	Theme Pile	Codes
The value of treatment	Hope in change	Psychology can make positive impact (Millar et al, 2012) Value of experience (Millar et al, 2012) Successful ending to therapy (Millar et al, 2012) Hope that can change (Millar et al, 2012) Changes through therapeutic relationship gratifying (Kurtz & Turner, 2007) Satisfaction develops out of difficulties (Kurtz & Turner, 2007) Satisfaction from therapeutic work- directly addressing interpersonal problems (Kurtz & Turner, 2007) Experience gives benefit of hindsight (Millar et al, 2012) Future for the patient(O'Brien & Flote, 1997) Changing reaction based on experience (Nehls, 2000) Successful outcomes shared by experienced nurses (Ma et al, 2009) Belief that behaviours were modifiable (Ma et al, 2009) Belief in outcome empowered willingness to face challenges (Ma et al, 2009) Individualised nursing interventions based on patient's characteristics (Ma et al, 2009) Seeing patient get better-positive experience (Woollaston & Hixenbaugh, 2008) Receiving recognition and praise good (Kurtz & Turner, 2007) Encouraging patients to take responsibility (Kurtz & Turner, 2007) Sense of purpose (Kurtz & Turner, 2007) Importance of patient' openness and honesty in moving forward (Kurtz & Turner, 2007) Open talking regarded as significant progress (Kurtz & Turner, 2007) Trying to empower the person (O'Connell & Dowling, 2013)
	Positive emotions	Feeling physically safe (Kurtz & Turner, 2007) Feelings of fondness and protection (Kurtz & Turner, 2007) Try to be open and non-judgmental (McGrath & Dowling, 2012)

	Ward provoking without empathy (Bergman & Eckerdal, 2000)
	Empathy personal equipment to deal with helplessness of patient (Bergman & Eckerdal, 2000)
	Importance of empathy, nearness and warmth (Bergman & Eckerdal, 2000)
	Engage on human and emotional level (Stroud & Parsons, 2012)
	Seeing as a person (Stroud & Parsons, 2012)
	Strong desire to help (Stroud & Parsons, 2012)
	Interest in particular clients (Millar et al 2012)
	Interest in clients (Millar et al, 2012)
	Empathy towards clients (Millar et al, 2012)
	Likeable individuals (Millar et al, 2012)
	Forces that keep motivation there (Bergman & Eckerdal, 2000)
	Keeping in touch with helping the patients with symptoms (Bergman & Eckerdal, 2000)
	Feelings of admiration compassion, warmth, sadness and empathy (O'Brien & Flote, 1997)
	Personal attributes of staff (Crawford et al, 2010)
	Staff attitudes more important than qualifications (Crawford et al, 2010)
Challenges and personal gains	Not purely individual client work (Millar et al, 2012)
	Providing a sense of reward (Millar et al, 2012)
	Hard won development of understanding problems (Kurtz & Turner, 2007)
	Other jobs would be boring by comparison (Kurtz & Turner, 2007)
	Satisfaction and stimulation (Kurtz & Turner, 2007)
	Exciting and cutting edge (Kurtz & Turner, 2007)
	Understanding= personal satisfaction (Kurtz & Turner, 2007)
	Steep learning curve (Millar et al, 2012)
	Confusion and complexity (Millar et al, 2012)
	Challenging and complex (Stroud & Parsons, 2012)
	Demands placed (Stroud & Parsons, 2012)
	Complex clients (Stroud & Parsons, 2012)
	Challenging and difficult (McGrath & Dowling, 2012)
	Satisfaction= enjoying challenge (Risq, 2012)
	Challenge of job attractive (Kurtz & Turner, 2007)
	Lack of knowledge and understanding adds to mystique (Kurtz & Turner, 2007)
	Clinical work difficult and different (Kurtz & Turner, 2007)

	Experiences of working with good and bad (O'Connell & Dowling, 2013)	
	Positive aspects of work (Crawford et al, 2010)	
	Never boring (Crawford et al, 2010)	
	Personal satisfaction from work (Crawford et al, 2010)	
Trying to Understand	Similarities to other clients (Millar et al, 2012)	
	Explaining function of behaviour (Millar et al, 2012)	
	Using formulation (Millar et al, 2012)	
	Factors that might explain difficulties (Millar et al, 2012)	
	Searching for explanations (Millar et al, 2012)	
	Importance of early life experiences including trauma (Stroud & Parsons, 2012)	
	Struggling to understand self-harm (O'Brien & Flote, 1997)	
	Struggle to understand reflected patients feelings of derealisation (O'Brien & Flote, 1997)	
	Wanted explanations (O'Brien & Flote, 1997)	
	Unable to cope with life and need help (Woollaston & Hixenbaugh, 2008)	
	Reasons for no boundaries in BPD (McGrath & Dowling, 2012)	
	Looking beyond behaviours- whole person functioning (Kurtz & Turner, 2007)	
	Integrating understanding of aggression and vulnerabilities hard (Kurtz & Turner, 2007)	
	Hard to link person with violent offences (Kurtz & Turner, 2007)	
	Hard for objective view- stigma (Commons-Treloar, 2009)	
	Insight into the underlying causes- communicating distress (Commons-Treloar, 2009)	
	Let down so many time before (Risq, 2012)	
	Seeking understanding- thinking about the past (Risq, 2012)	
	Gut reaction (Risq, 2012)	
	Signs of pd: anger, paranoia, relationships (Risq, 2012)	
	Engagement depends on understanding behaviour and attitude (Stroud & Parsons, 2012)	
	Diverse combination of symptoms and issues (O'Connell & Dowling, 2013)	
	Challenges of working with PD (Crawford et al, 2010)	
	Experienced a traumatic childhood (O'Connell & Dowling, 2013)	
Inadequacy of the system	No shared goals across professionals (Millar et al, 2012)	
	Financial and time constraints of NHS (Millar et al, 2012)	
	Inadequacy of society to listen to patients (Bergman & Eckerdal, 2000)	
	Inadequacy of organization to meet needs (Bergman & Eckerdal, 2000)	

	No cooperation and harmony with services (Bergman & Eckerdal, 2000)	
	High work load, lack of time (Bergman & Eckerdal, 2000)	
	No place to discuss emotions (O'Brien & Flote, 1997)	
	Unpleasant working environment (McGrath & Dowling, 2012)	
	Outsiders seeing PD as not treatable (Kurtz & Turner, 2007)	
	Outside lack of knowledge and no motivation to learn (Kurtz & Turner, 2007)	
	Lack of support and interest in work by outside (Kurtz & Turner, 2007)	
	Media ignorant and hostile towards patient group (Kurtz & Turner, 2007)	
	Clearly a group of people who need something (Commons-Treloar, 2009)	
	Concerns of health system to meet needs (Commons-Treloar, 2009)	
	Someone needs to help (Risq, 2012)	
	Lack of social responsibility for clients (Risq, 2012)	
	Need for long input (Stroud & Parsons, 2012)	
	Justifying extra effort (Risq, 2012)	
	Working round the system (Risq, 2012)	
	Relief when handing over (Risq, 2012)	
	Long term approach needed (Risq, 2012)	
	Guilt about work that can be offered (Risq, 2012)	
Need for knowledge	Desire to learn more (Millar et al, 2012)	
	Lack of understanding leads to pejorative terns to explain behaviours (Stroud & Parsons, 2012)	
	Without knowledge framework-limited understanding (Stroud & Parsons, 2012)	
	Limited knowledge (Stroud & Parsons, 2012)	
	More knowledge needed (Bergman & Eckerdal, 2000)	
	Need a better knowledge of how to relate (Bergman & Eckerdal, 2000)	
	Lack of knowledge base and resources (Commons-Treloar, 2009)	
	Lacking knowledge and background (Risq, 2012)	
	Uncertainty of contract and treatment plan (O'Brien & Flote, 1997)	
	Unsure about interventions (O'Brien & Flote, 1997)	
	Lack of clarity around BPD (O'Connell & Dowling, 2013)	
Feeling Inadequate	Low ability to deal with clients (Millar et al, 2012)	
	Low self-efficacy (Millar et al, 2012)	
	Feeling in-equipped (Millar et al, 2012)	

	Doubts about professional skills (Bergman & Eckerdal, 2000)
	Not having right competence (Bergman & Eckerdal, 2000)
	Feeling inadequate (Bergman & Eckerdal, 2000)
	Feelings of hopelessness (Woollaston & Hixenbaugh, 2008)
	Knowledge of specialist services led to feelings of inadequacy (Woollaston & Hixenbaugh, 2008)
	Feeling disheartened and frustrated (Woollaston & Hixenbaugh, 2008)
	Feeling incapable (Woollaston & Hixenbaugh, 2008)
	Frustrated, inadequate and challenged (Commons-Treloar, 2009)
	Inadequate, angry and powerless (Commons-Treloar, 2009)
	Re-traumatising people (Risq, 2012)
	Dilemma: brief work counterproductive (Risq, 2012)
	Feeling inadequate (Risq, 2012)
	Going to let them down (Risq, 2012)
	Inevitable disappointment: negative implications (Risq, 2012)
	Unspoken no-win contract: rules and expectations (Risq, 2012)
	High expectations from clients (Risq, 2012)
	Never good enough (Risq, 2012)
	Doubt about ability (Nehls, 2000)
	Difficulties in skills could be transference (Bergman & Eckerdal, 2000)
	Conflicting advice leads to lack of confidence (O'Brien & Flote, 1997)
	Not living up to expectations (Woollaston & Hixenbaugh, 2008)
	Feeling powerless (Millar et al, 2012)
Doing anything useful	Pessimism of value of treatment (Millar et al, 2012)
	Limited impact of psychology on intervention (Millar et al, 2012)
	Ability to change limited (Millar et al, 2012)
	Clients get stuck (Millar et al, 2012)
	Acceptance that can't always help (Woollaston & Hixenbaugh, 2008)
	Under pressure to help them (Millar et al, 2012)
	Clients self-defeatist (Millar et al, 2012)
	Few possibilities to exert influence (Bergman & Eckerdal, 2000)
	Little or no advantage in existing way of treating BPD (Bergman & Eckerdal, 2000)
	Experience BPD negatively due to being unable to help (Woollaston & Hixenbaugh, 2008)

Unable to treat these patients- not getting better (Woollaston & Hixenbaugh, 2008)
Being unable to help (Woollaston & Hixenbaugh, 2008)
Helping BPD waste of medical resources (Ma et al, 2009)
Negative expectations for outcome (Ma et al, 2009)
Tempted to abandon positive expectations for outcomes (Ma et al, 2009)
Expectations of care outcomes influence descion to interact (Ma et al, 2009)
Good care difficult (McGrath & Dowling, 2012)
Unlikely to be a cure but can be beneficial (Kurtz & Turner, 2007)
Waste of clinical time (Commons-Treloar, 2009)
Medicine used to calm down situation (Bergman & Eckerdal, 2000)
Doing anything useful (O'Brien & Flote, 1997)
Negative expectations led to routine care- only basic needs (Ma et al, 2009)
Boundaries emphasized over other treatments (Nehls, 2000)
Working on different levels (Millar et al, 2012)
Whether engaged as staff fluid (Stroud & Parsons, 2012)
Progress takes time (O'Connell & Dowling, 2013)
Feeling drained in lack of progress (O'Connell & Dowling, 2013)
Establishing trust slow (O'Connell & Dowling, 2013)
Need to accept limits of what can't be achieved (Crawford et al, 2010)

Appendix 1-B

Notes for Authors

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

Submissions
All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at http://mc.manuscriptcentral.com/cjmh . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.
The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

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

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

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

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the Keywords Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

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

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

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:
a) For journal articles (titles of journals should not be abbreviated):

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

Powell, T.J. & Enright, S.J. (1990) Anxiety and Stress management. London: Routledge
c) For chapters within multi-authored books:

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

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

Section Two: Research Paper

The Process of Change in Non-residential Therapeutic Communities

Word Count: 7,959

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Abstract

Background: The democratic therapeutic community (DTC) is a psychosocial intervention where the social environment acts as the therapeutic milieu. Empirical research has suggested the effectiveness of the DTC model for individuals with a diagnosis of personality disorder. Yet, limited research has explored non-residential communities or how the model helps service users work towards change. *Aims:* The aims of the project were to understand and construct a model of change from group members' perspectives. *Method:* Eleven participants were interviewed across six non-residential DTCs and grounded theory methodology was utilised to develop a model. *Results:* Difficult beginnings within the group were highlighted but as individuals were helped to find a voice they took on the identity of a group member and worked reciprocally to help themselves and others. *Conclusions:* The process of change within non-residential DTCs was described as a reciprocal process where each group member acted on both sides of the therapeutic relationship to work towards change. *Declaration of Interests:* None

Keywords

Therapeutic communities; process of change; grounded theory

Introduction

Mental health provision for individuals with a personality disorder diagnosis historically has been less accessible than for individuals with a mental illness diagnosis (National Institute for Mental Health in England [NIMHE], 2003). Debates around the personality disorder construct fitting into mental health services have long been sustained due to concerns it does not fit the dominant medical model (Eastman & Starling, 2006). Professional perspectives characterised individuals with this diagnosis as untreatable, potentially providing an instrumental reason for not providing care to individuals with these needs (Pickersgill, 2013). Furthermore, narratives that behaviours are intentional may lead to beliefs that individuals are undeserving of care (Woollaston & Hixenbaugh, 2008). These discourses had served to restrict individuals to the side-lines of the health care service (Bateman & Tyrer, 2004). Indeed, a 2002 survey concluded that only 40% of National Health Service (NHS) mental health trusts met the needs of these service users, with only 17% having specialist facilities (NIMHE, 2003).

More recently, a shift towards inclusion has occurred. The dominant discourse of un-treatability has been challenged through increasing academic units, professional networks and public spending on services and research (Pickersgill, 2013). Government guidelines emphasised the importance of providing more specialist psychological treatments (National Institute for Health and Care Excellence [NICE], 2009). Thus, clinicians have attempted to de-stigmatise this diagnosis and increase their ethical duty over the provision of care (Pidd & Feigenbaum, 2007). Psychological interventions for this client group have become more prevalent through interventions like dialectical behaviour therapy (Linehan, 1993), mentalisation based therapy (Bateman & Fonagy, 2006) and structured clinical management (Bateman & Krawitz, 2013). The democratic therapeutic community (DTC) forms another psychosocial intervention available within some NHS trusts. A variety of DTC models exist

in the UK, including within prisons (Campling, 2001), high secure hospitals (Taylor,

Morrissey, Trout & Bennett, 2012) and non-residential groups which meet for a varying

number of days a week (Pierce & Haigh, 2008).

        The roots of the DTC are traced to the end of the Second World War where Mill Hill

and Northfield hospitals were developed to provide care for returning soldiers (Whiteley,

2004). The social context was utilised as a space where personal change could be facilitated,

representing a shift from the current dominant psychiatric model (Barr, Hodge & Kirkcaldy,

2008). Maxwell Jones, the director of the Henderson Hospital, is seen as a key figure in the

development of the model. He emphasised communication and encouraging group members

to input into community meetings, a core element of the model (Whiteley, 2004). Thus, the

model was designed to give power to community members signifying change from power

being held by professionals. An ethnographic study of the Henderson Hospital

conceptualised four hallmarks of the model: democratisation, permissiveness, reality

confrontation and communalism (Rapoport, 1960). Democratisation notes the equal

contribution of all members to the group's decision making. Permissiveness indicates all

behaviour should be accepted, even if it causes distress. Reality confrontation suggests that

members should be challenged with the group's perceptions of their behaviour. Rapoport

(1960) used communalism to make explicit the open communication expected.

        Haigh (1999) updated these ideas to identify five essential qualities of DTCs:

attachment, containment, open communication, involvement and agency. Attachment refers

to belonging in the group, helping make changes in relational patterns. Containment

represents the group containing difficult experiences, through building relationships, the

structures and boundaries (Haigh, 1999). This corresponds to Rapoport's (1960)

permissiveness; however, Haigh emphasises the importance of safety. Open communication

refers to the openness present to promote enquiry, possible once containment and attachment

are developed. Involvement highlights that change is worked towards within all group

activities. Agency emphasises that the knowledge and contribution of group members

provides more therapeutic value than that of staff (Haigh, 1999).

Early DTCs were residential and required individuals to live within the community

(Rutter & Crawford, 2005). However, through NHS funding changes from national to local

structures, residential communities became financially unsustainable leading to a number of

closures (Pearce & Haigh, 2008). Resultantly, a recent shift transpired from residential to

non-residential DTCs, with the latter fitting with local funding and thus being more

financially sustainable. Pearce and Haigh (2008) distinguished between non-residential

DTCs, terming groups meeting three-five days a week 'day DTCs' and those meeting for less

'mini DTCs'. However, research by Barr et al. (2010) exploring groups meeting one day a

week utilised the term 'non-residential DTCs', which will be the term used within this paper.

Following a similar model to residential communities the group context is seen as the

vehicle of change within non-residential DTCs. An individual attends for 12-18 months,

depending on the community, and is expected to attend each week (Hellin, 2006). The

groups work democratically, meaning every decision is voted on and the majority decision is

agreed. The structure of groups varies across trusts; however, each day has a set structure

around different activities (Hellin, 2006). The groups have regular reviews to highlight

individual progress and discuss goals. Group members are given jobs to help the group run,

ensuring that structures are adhered to and to encourage responsibility.

Research has explored the effectiveness of the DTC approach. Through a meta-

analysis of 29 studies, Lees, Manning and Rawlings (2004) concluded that although the

studies were of low quality there was evidence for the effectiveness of this approach. Dolan,

Warren and Norton (1997), demonstrated that compared with a control group, DTC members

reported a significantly greater reduction in symptoms, accounting for clinically significant

change in 42.9% of service users. Additionally, Davies and Campling (2003) highlighted a

reduction in service use following attending a therapeutic community.

Yet, there is limited research exploring non-residential communities. Barr et al.

(2010) explored the DTC model within four one-day a week communities. The results

highlighted improvements in mental health and social functioning, indicated across staff and

service user reports. Within the same study, Hodge et al. (2010) explored the experiences of

individuals attending these DTCs qualitatively. This indicated that service users developed

better ways of relating to others and became less reliant on self-harm as a coping strategy.

However, this study explored service users' experience in general and did not explore what

was helpful about the model. Shine and Morris (2000) highlight the importance of

constructing models of change to understand the unique processes within therapeutic

communities and this may make the model more accessible. As yet, no studies have explored

the process by which non-residential DTCs help service users change. This study helps to fill

this gap by exploring change from group members' perspectives. Thus, the aims of the

current study were to explore the process of change and develop a model in non-residential

therapeutic communities.

Method

Design

A grounded theory methodology was utilised to fit with the aims of the study as

grounded theory allows an exploration of how a construct like change is achieved and the

structures and processes that support this (Starks & Brown-Trinidad, 2007). Within grounded

theory there are a number of approaches aligned to different epistemological stances

including a positivist stance (Glaser & Straus, 1967) and constructivist approaches (Charmaz,

2006). Fitting with the researcher's epistemological stance, the constructivist approach

outlined by Charmaz (2006) was utilised as it recognises the active relationship the researcher

has with the data, moving away from the original conceptualisation of grounded theory which considered the researcher as a passive observer.

The study was developed with guidance from a network of therapeutic communities in the North of England. The researcher presented the proposal at a meeting which included staff and service user consultants from non-residential DTCs, with the feedback guiding the design of the study. For example, the eligibility criteria for the study were considered. The meeting was also a way of gauging the interest of the communities to act as recruitment sites. The participant information sheet and interview guide were reviewed by service user consultants from the main recruiting trust, the feedback helping adapt the recruitment documents.

Procedure

Recruitment.

Recruitment took place across six non-residential DTCs. Following ethical approval and approval from each trust (see ethics section), the researcher applied to each DTC requesting to visit. The researcher spoke about the research and answered any questions the group had. Group members could opt into the study if they had been attending the group for nine months and had experienced change. The definition of therapeutic change may differ depending on the individual and their diverse needs (Carey, Carey, Mullan, Murray & Spratt, 2006). Thus, change was defined by the individual and not by applying a preconceived outcome measure. Group members were given a recruitment pack including a covering letter, participant information sheet, opt-in form and a postage paid envelope. Individuals could opt-in to the study by posting back the opt-in form or by speaking to the researcher at the meeting.

Participants and data collection.

When an individual opted into the study, the researcher contacted them to answer any questions and arrange a time and place to undertake the interview. Fourteen individuals opted into the study. One participant cancelled the interview through ill health and did not attend the re-arranged interview. A subsequent attempt to contact them was unsuccessful so it was assumed they no longer wished to take part. A further two individuals opted-in but then withdrew for personal reasons. Consequently, eleven participants took part in the study. Table 1 details the participants' demographics.

Insert Table 1 here

Data was collected through semi-structured interviews. Participants were given the choice of interview location from the service base, where the DTC met or in a community venue: three participants were interviewed at the service base, one participant where the DTC met, four were interviewed at GPs' surgeries and three were interviewed at children's centres. Participants were asked to re-read the participant information sheet, asked if they had any questions and were asked to sign the consent form. Interviews lasted between 56 minutes and 2 hours 11 minutes and were digitally recorded. Each participant was given a pseudonym to ensure their confidentiality.

Analysis.

In accordance with grounded theory method, data collection and analysis took place simultaneously (Charmaz, 2006). This meant that five participants were interviewed first and a preliminary analysis took place to guide areas for future interviews. The remaining six participants were then interviewed, with analysis occurring after each interview where

possible. At this point, it was considered that theoretical sufficiency had been reached, a point where additional data does not revise existing categories (Dey, 1999).

Each interview was transcribed by the researcher and coded (see appendix 2-A). The initial coding for each transcript involved naming each segment of data in line-by-line coding (Charmaz, 2006). The researcher coded with gerunds where possible to identify processes in the data. Focussed coding was undertaken to generate codes that explained larger sections of data. The focussed codes of the first five transcripts were colour coded and entered into an Excel spreadsheet and compared to highlight similarities and differences. These were grouped into provisional conceptual categories and links between them were explored. From this a provisional model was developed. This model highlighted sections that required exploration in subsequent interviews. The remaining interviews were then conducted, transcribed and coded as detailed above. Throughout this process memos were written which documented the researcher's interpretations and reflections of the interviews and process of coding transcripts. These memos helped inform the final model by conceptualising ideas that formed categories and links between them (Charmaz, 2006). The focussed codes from the final interviews were compared with the provisional conceptual categories. The focussed codes were added to these to strengthen the understanding of a concept, or where new codes suggested a different process the categories were adapted to take account of the new information. This process detailed the final conceptual categories and the links between them, developing a model of the process of change grounded in the participants' data.

Reflexivity and Credibility

Charmaz (2006) argues for the recognition of the active role of the researcher within research. Thus, it is important for the researcher to acknowledge their position in relation to the data (Yardley, 2000). The researcher is a trainee clinical psychologist with previous experience of working with individuals with a diagnosis of personality disorder. The

researcher has an interest in psychological change and different models of care. The researcher had no clinical experience of a DTC but attended a day within a community. Reading the literature around DTCs was postponed until the data was collected, in line with guidance for conducting grounded theory.

The researcher utilised a reflective diary throughout the research, documenting any assumptions or reflections relating to the research. The research was conducted under the supervision of a tutor with experience of qualitative research. With this, the initial interview was reviewed to guide future interviews and the coding was checked to ensure coherence. All steps of the analysis are detailed above and the results are grounded in the words of the participants. A grounded theory support group was created with peers and this was utilised to discuss the methodology and any difficulties that arose.

<h3 style="text-align:center">Results</h3>

Following the analysis, a model of the process of change in non-residential therapeutic communities was developed, grounded in the narratives of the participants. This model is explored narratively and presented diagrammatically below.

Joining the Group

The initial stage of the model focussed on individuals' experiences of joining which was "highly traumatic" (Jo) and "nerve wracking" (Garry). As part of joining, individuals attended a selection meeting where they articulated why they wanted to join. This was "really scary. It was harder than I remember going for a job interview" (Tony). Individuals felt under the "spotlight" (April) and speaking in the group was distressing: "I didn't talk. At all" (Megan). In attending the group, individuals had overcome emotional and physical barriers and challenged themselves: "they're asking you to do things that pretty much you've already shut down: going new places, getting out in the car or getting on the bus" (Jo).

On being accepted, individuals joined the group, immediately hearing difficult stories and past experiences. Remaining in the room was challenging and new members became "hyper-vigilant" (Tony) or had "panic attacks" (Grace) due to high levels of anxiety. Joining an already formed group amplified the feeling of not fitting in that had been experienced outside the group: "I felt a bit of an outsider at first, erm cos the group was so well established" (Barbara). This "being the new kid" (Emma) increased when differences were highlighted such as when topics were not directly relevant or in being the only male: "I'm a bloke, I'm like the parent, I'm like a fella, so you feel, you tend to notice that a little bit" (Andy).

Adapting to the unique structures of the community and synthesising expectations of the group with their hopes was difficult. Learning to be in the group was adapting to an unknown process and not understanding the group mechanisms made it more difficult to come back: "nothing makes sense so you're…surrounded by all these random people, just like I'm not supposed to be here" (Megan). This made it more challenging to share information with the group as it was unclear how this would help. Participants articulated their hope for a "cure" (Garry) but adapted, thinking this may be unrealistic: "I realise the best I can hope for is a quality, an improvement in quality in my life because I didn't think they can cure you" (Jo).

The group structures, such as strict timings, were unfamiliar and made the group seem even harder to join. Though the group members helped ease individuals' initial experiences and explained about the group, it only started to make sense with experience: "you only realise it's good when it's at the end, when you've experienced it" (Dee). In this early stage, new members were not actively using the group, being unaware of how to do this and unsure about opening up. As a result, joining was tough, with positive change not happening at the beginning: "it always gets worse before it gets better" (Megan). This

related to experiences of "opening up old wounds and you'll be triggered by things other

people are saying" (April). Hearing others share traumatic experiences led to new members

"raking up your own history" (Tony) and experiencing flashbacks. This had the potential to

increase risk: for some, starting the group made them feel "more suicidal" (Andy) or

increased the number of "overdoses" (Cathy) within this period.

Participants described "thinking about quitting" (April) and so joining took "a lot of

commitment to get through" (Jo) and this was paramount to come "out the other end"

(Andy). Making themselves attend at difficult times was important: "I think I don't want to

go in this week and I force myself in" (Emma). For some, the motivating factor was the lack

of options within services: "you do tend to go back, like there's no other option really"

(Megan). The group was seen as the "last chance saloon. It's the only help that you can see

that's out there" (Jo).

Being Helped to Find a Voice

Following joining the group, participants described the next part of the process as

learning to speak in the group. In early stages, new members were allowed to be quiet, but as

time progressed, they were encouraged by the group to participate. Learning to be in the

group and learning how to talk was fundamental in being able to utilise the group for change.

Yet, learning to speak represented a change in itself: "I was like the quietest person ever and

I didn't speak to anyone" (Megan). Time was important in this process and the group's long

time frame helped this feel less pressured: "I just got to that point, I had things to say and I

wanted to say them" (Barbara). This was an active process so the individual needed to be

willing to take the help offered. Individuals were not expected to share early on but were

gradually encouraged by the group: "we wouldn't be brow beating them saying you're not

talking enough" (Andy). Talking to strangers was tough, especially with personal topics so

getting to know people was paramount in being able to share: "they can relate to me in this way so maybe if I start bringing myself out in other ways" (Megan).

This process was made easier by the structures that group members utilised to help new members. Existing members had this knowledge by using their experience of joining and seeing the process from "the other side" (Garry). This empathy and understanding resulted in practical strategies to help: "I just thought to myself, I was like this, I just, I was like this" (Tony). Structures in the group called 'participation' or 'suitability' were concrete ways of getting members to speak by protecting time for them in the group. New members were encouraged to speak by being brought into conversations, being asked questions and being encouraged to "integrate into the group" (Emma). The structure of the day, including sections where everyone was expected to speak such as 'name rounds' where everyone introduced themselves or 'risk' where risk issues were shared, was essential in getting people to talk: "a less structured group, you wouldn't have to say what your risk had been that week. You could probably get away with just not saying anything" (Jo). The group and staff members encouraging individuals to speak gave people "a voice" (Tony) and thus helped people integrate into the group.

Group as Safety

Through learning to speak, group members were able to share information to build trust and a safe environment from which they could begin to make changes. Building trust was imperative in being able to use the group: "you've got to overcome the initial…untrusting" (Barbara). With a new member there was a reciprocal process where individual and group learnt to trust each other, this was akin to a "stranger joining your family" (Dee). Group members put their guard up and shared less until some trust was established. Trust was built gradually through sharing information or offering comments;

when one shared, this made others willing to share. A lack of trust stifled people's ability to speak and so hindered their capacity to use the group.

Gaining trust created a space in which people were accepted unconditionally, contrasting to experiences outside of the group: "you're not judged and they're very supportive" (Grace). This space, used to offload or vent, acted as a safety net if someone had had a difficult week. Individuals were able to discuss anything, with nothing being "taboo" (Andy). The group adapted to keep this safety, which was a key factor in deciding whether new members would fit into the group. Importantly, emotions could be expressed without fear of being rejected or reprimanded. Individuals were allowed to become angry or frustrated and were encouraged to use those emotions as a learning experience: "frustration is encouraged because then you see what the matter really is" (Andy). Having a safe place made it easier for individuals to challenge themselves within the group and then attempt to make those changes outside: "it all challenges you but in what you become to feel like a safe environment" (Jo). This feeling of safety was not present outside the group but by having contact with group members in-between days, this safety was expanded outside of the group and allowed members to cope better: "if a group member was low they'll ring the person that they trust the most in the group and then like that person will help them" (Emma).

Having an Identity as a Group Member

Having a safe environment and sharing information promoted the experience of fitting in and becoming a group member. Participants highlighted the identity they gained on integrating into the group: "you're a member of the group, you've got to be a part of that" (Cathy). Becoming a group member was a significant process that highlighted getting through the difficult beginning and finding somewhere they belonged. The group was described as tangible and distinct from the outside world. Each individual brought something to the group and this created something to help each member: "that's how the

group works, it's weird, it just connects, the jigsaw and the puzzle fits and it comes together"

(Dee). There was a process of getting to know others and being known by the group.

Through being known, the group treated them as an individual and worked together to help,

knowing what they needed. Group members "attach to people and they make you feel safe"

(Megan) and through this developed friendships and connections. This attaching was

therapeutic as participants learnt how to communicate and how to be in supportive

relationships. Belonging helped increase people's confidence: "you matter to the group,

you're an important part of it, and just knowing that can boost your self-esteem" (April).

Getting to know each other and relating to each other created a powerful experience

of "being in the same boat" (Jo, Barbara, Emma, Megan) which strengthened the group and

validated experiences. Each group member was learning from people with lived experience

and was helping others through their own experiences. Acting to help each other created a

momentum allowing the group members to use the group: "they have been through problems

and they are similar to you so…it seems better coming from them" (Garry). Being a group

member meant that, at times, the group was placed above the individual's fears and people

changed to not let the group down: "I nearly took an overdose the other week but I thought,

no I can't let the group down, they'll be gutted if I end up back in hospital" (Barbara).

Job roles.

Part of the process of becoming a group member was the responsibility that this

involved. Members are responsible for running the group, so all members have jobs such as

chairperson or timekeeper. Being given a job straight after joining was hard and people tried

to hide behind easier jobs: "I shied away from it, but they don't let you" (Grace). Jobs were

an integral part of the therapy: the responsibility was something that individuals were not

used to or had avoided. Group members were encouraged to have roles that would align with

their needs: someone who was struggling to talk would be encouraged to become the

chairperson. Taking on responsibility through jobs empowered group members, increased

their confidence and made them realise the skills they had. With the jobs being fundamental

to the group, people felt more integrated and this gave them a purpose within the group. The

jobs acted "just to keep it our group, not the staff members" (Barbara).

Giving and Taking

Gaining the identity of a group member promoted the responsibility of the individuals

to use the group for themselves and help other people within the group. The reciprocal nature

of being a group member was apparent throughout the participants' narratives. The input of

other group members was vital and all were involved in "giving and taking" (Barbara). This

was not individual therapy in a group setting, rather the agent of change was the group and

all members were therapeutic input for each other. Being a group member therefore involved

acting in a reciprocal way: each member was responsible for challenging others, asking

questions to develop understanding and giving advice to others.

On an individual basis, it was important to "use the therapy well" (Dee). To utilise

the group individuals had to be active and push themselves. Due to being in a group,

individuals had to "take all opportunities" (Emma), be honest and bring things to talk about.

At times, individuals had to be selfish and take responsibility for their own therapy: "it's all

down to me to sort myself out" (Garry). A key theme articulated was that an individual

would get out of the group what they put in. Progress depended on how willing an individual

was to challenge themselves: "I think it just depends how you take it and how willing you

are" (Megan). At other times group members prioritised the needs of others: it was important

to remember that it was "not all about you" (Cathy).

Individuals used the space to talk through difficulties and to gain the perspective of

the group. Initially, it was hard to talk about past experiences: "you're expected to open up,

that's what you're there for. There's no point in going and just sitting there" (Cathy).

Sharing this was fundamental in using the group. Before sharing, people were not using the group as effectively as they could: "I don't think I was using it to its fullest capacity" (Andy). The groups had 'reflective space' where difficulties were explored. This space was unstructured and conversations could start in various ways. An individual might start with a specific topic with discussions arising from there, a group member could be asked a question, staff might start a topic or if risk had been highlighted earlier in the day then this would be explored. In each conversation, every group member might have acquired something different. In being the person speaking, or a group member challenging there was therapeutic potential: "you are using it when you're listening and when you're listening you're taking on board what they're saying and you can relate to it" (Dee).

Indeed, listening to others was fundamental within the group and individuals were able to "learn a lot by listening" (Jo). This helped validate the listener's emotions and experiences through recognising aspects of themselves they were unaware of. Thus, this increased the listener's own self-awareness. Hearing others' stories and current dilemmas helped all the group see the multitude of ways that people reacted in similar situations and so helped share different ways of coping: "We all like help each other in that way…. I said something and she said…I've never thought of it like that, but it made her stop and think" (Grace). Of importance for the reciprocal nature of the group, hearing other people share their past helped others open up and share their own past to help others in distress: "it's usually when you try and help somebody else that you first start coming out your shell, it's not when you're talking about yourself" (Andy).

Through discussions, individuals' opinions and behaviour were challenged by other group members. Being challenged was difficult but necessary. Discussions where everybody joined in acted as a challenge for all: "that person's then like challenging the other person on their thoughts and that can go round the group where everybody is challenging

each other" (Emma). At times, challenges were more direct but people understood this was

necessary: "sometimes people need to hear blunt which can be hurtful…you need to be like

tough, but kind" (Cathy). This was seen as fundamentally different from individual therapy

where therapists were understanding but not challenging. Being challenged was a strategy

used to make individuals angry or frustrated so they would open up: "they just kept prodding

at it and I could feel myself getting more and more wound up and then all this big verbal

thing" (Andy). This was accepted in the safety of the therapeutic space as it was done with

the interest of the individual in mind: "I know they're only looking after my best interests"

(Barbara). At times when conflict was present, this was seen as an opportunity to learn, from

seeing different opinions and sitting with difference.

As well as being challenged, individuals took advice from other group members on

problems, how to deal differently with a situation or learning ways of coping with risk. This

advice was insightful and powerful, coming from individuals with similar experiences and so

was better than advice from professionals: "they have more gravitas" (Jo), as they knew how

they were feeling: "it seems better coming from them, cos they, I think they can understand

more on how you're feeling" (Garry). Advice giving helped all group members learn from

one situation through hearing different ways people act.

Increasing understanding.

Through talking in the group and listening to group members' stories, individuals

increased understanding of their own difficulties and how the past had impacted on them.

Being in the group helped ascertain what needed to change, through group members pointing

this out: "making you realise…what I should be doing and you know things that I've done

wrong" (Grace). This sharing experience increased individuals' understanding of the triggers

that increased their risk: "if you can take those triggers away… you're able to deal with not

getting to that heightened state of I want to die right now" (Andy). From understanding,

group members were able to realise areas to focus on, slow situations down and work

towards changing their reactions.

Synthesising and practising.

The safety of the group was then used to practise skills or solutions before trying to

implement these outside. Change on the outside was harder due to the unsafe environment

where others did not understand them. Part of the consolidation process was reflecting on

experiences, challenges and advice at home. The group was "moving all day" (Emma) so

there was limited time to think about what had been said. Participants reflected on advice

and waited for it to "sink in eventually" (Megan). This allowed individuals to question how

they reacted: "people have sown seeds in your head about questioning how you cope" (Jo).

Thus, the group challenged even when they were not present. Individuals imagined what

group members would say and this helped to slow things down, change behaviour or

understand why: "things people have said to me in the group and I realise 'oh, I'm doing that

again aren't I'? and then I best change that" (Garry).

Reviews.

Reviews, a protected space every few months where individuals were asked questions

to elicit how they had changed, were seen as a vital structure that helped make explicit

individuals' progress. Participants struggled to recognise change in themselves and so

receiving feedback from the group in reviews was essential: "you can't be properly aware of

something until someone else points it out for you and then you can start to change" (Garry).

Questions were the same across reviews so members were able to track their progress. Part

of the review looked at goals for the next period and this helped maintain change that had

already happened. Seeing change allowed individuals to put more of themselves into the

group: "you're feeling better now with only trying it a bit, what happens if you try it, you

know if you dive fully in so to speak" (Andy).

Becoming a Senior Member

As time within the group increased and change was noticed, group members became more senior within the group. Working towards change was a "team effort" (Andy) which helped each individual through the process as they joined. As group members became more senior, they acted to help newer members, and so the group continued helping as members joined, worked towards change and then left. Knowing the group meant that individuals ensured new members were able to "stick with it in the beginning" (Tony). This came from empathy and experience of the difficult beginning. New members looked towards more experienced members to lead: "when the older members leave you get more responsibility like you can't sit and be quiet because the people who are just joining they want to be quiet" (Megan).

Group Structures

Participants spoke about the group structures that were fundamental in supporting the mechanisms described above. The long time frame of the group removed the pressure of needing to improve quickly, in contrast to experiences of services where there was pressure to improve within six sessions: "the time scale's long, gives you long enough to have a go, make a mistake, readjust" (Jo).

The staff were seen as a fundamental part of the structure: "I think we need the staff members" (Grace). However, they were not seen as part of the group and were not the main agent of change. The therapeutic relationship was not described between staff and group member but between group member and the group. Staff were important, but were in the background and were responsible for overseeing the group: "I call them the motorway signs, you know you go down a country lane and you go off track, they get us back on track" (Dee). Staff were key in recognising when an individual was quiet and bringing them into conversations or challenging them. Staff were seen as a safety net to keep people safe and

reduce anxiety. Service user consultants, who had previously been through the group and were now employed within the groups, were seen as bridging the gap between staff and the group. Participants were unclear about the value they added but felt they were useful in giving suggestions and keeping the boundaries and structures.

Individuals spoke about the unique structures that provided a containing space for the group. Each day had a set of specific tasks with specific timings and when each section finished time was called and the group moved on, even if someone was still speaking. This was described as being like "army military" (Dee) and was initially difficult to comprehend though were described as fundamental to the group. They maintained consistency so each member was aware of what was expected of them. This acted to reduce anxiety so group members were more able to use the group: "it makes everything safe and predictable which is good" (Megan). Specific structures helped to keep group members safe by giving people time to explore risk and in giving people a space to calm down before leaving. Adhering to the structures provided a sense of equality across group members, with everybody having a chance to speak. Without the structures present there was an understanding that the day would be chaotic and nothing would be discussed. Thus, the structures provide the containment for people to be able to utilise the group to work towards change.

Insert figure 1 here

Discussion

The aim of the study was to understand the process of change in non-residential therapeutic communities. The original conceptualisation of the research focussed on the individual process of change. Whilst this is represented within the model, the main focus is upon the mechanisms as they operate within the group and how the group affected change for

its members. This may be reflective of the experience of being a group member and accordingly working in a reciprocal role to help yourself and others.

The initial stage of the model detailed the difficult beginning of the group. Participants described this as traumatic and felt their difficulties became worse before getting better. This acted to increase the risk to self. Participants articulated thinking about leaving and it required a high level of motivation and commitment to continue. Hummelen, Wilberg and Karterud (2007) noted a high drop-out in group therapy for individuals with a diagnosis of Borderline Personality Disorder, related to increased negative affect on joining. Learning to be in the group represented a change for the participants who described entering the group from isolation. Participants were not fully using the group at this stage, yet getting through this section was fundamental to using the group at a later date.

Within this stage a reciprocal process was described where the individual attempted to talk whilst existing members used practical strategies to help. This interaction was key in helping new members integrate into the group and become a group member. Sharing information was key in creating a trusting environment, knowing other members and belonging in the group. Yalom and Leszcz (2005) argue that individuals entering therapy believe they alone experience difficulties and this was highlighted in the narratives of the participants. Joining the group from isolation and experiencing others "in the same boat" was a powerful moment which increased feelings of belonging. Haigh (1999) reasoned that belonging and safety need to be present for individuals to open up, with individuals needing to ensure that they would be accepted. This was largely reflected in the current results with individuals describing the importance of trust and a safe space. Yet, getting to this safety required individuals to have shared information. This was seen as a reciprocal process as when a new member joined existing group members became more withdrawn and had to learn to re-open up. Without this sharing, the trust and safe environment were not present.

Thus, Haigh's (1999) ideas may not reflect the reciprocal nature of the process, nor the changing nature of the group as members join and leave.

Participants described taking on the identity of a group member. This was important in acting for the group and thus enabling members to use the power of the group for change. Karterud and Bateman (2012) hypothesised that within groups the individual changes through taking on the identity of a group member. Foulkes (1975) posits that though each member of a psychotherapy group may have difficulties, the group as a whole can recompense for these and create a safe place. This was described in the current results with the coming together of the group being described like a jigsaw with each member representing a different piece.

Research has suggested that a fundamental factor influencing the outcome of therapy is the therapeutic relationship (Martin, Garske & Davis, 2000). Yet, within this study, individuals described other group members as the active agents of change, not the staff. Staff were vital, but were in the background. On joining the group, service users became a part of the therapeutic process for others, being both service user and group member. Group members acted on both sides of the therapeutic alliance and the alliance they form is with the group (Campling, 1999). This has been termed 'cohesion' when applied to groups and is indicative of the connection between group members. Burlingame, McClendon and Alonso (2011) demonstrated that a higher reported level of cohesion was correlated with a statistically improved outcome. For the participants in the current study, the cohesion was cemented through relating to each other and sharing similar experiences. Pearce and Pickard (2013) suggest 'belongingness' is a key factor in the effectiveness of the DTC model. Indeed, they argue that is specific to therapeutic communities and may be lacking within other treatment approaches.

This cohesion and trust created a safe and containing place where change could be worked towards. Haigh (1999) argues that when working with individuals who may have experienced early disrupted attachments, a key task is to work towards a secure attachment and then use this to explore relationships and patterns of behaviour. Through attachment, an individual is able to develop more of an understanding of their own and others' minds and therefore develop a capacity to be reflective (Levy et al, 2006). This narrative is echoed within the current findings. However, participants indicated that this would never be achieved in individual therapy with it being imperative to have other service users present. This attachment acted as a secure base for participants to explore experiences, develop understanding, consider new ways of acting and practise skills. Thus, conversations within the group enabled individuals to develop a deeper understanding and then use this to work towards change (Haigh, 1999). This safety also allowed individuals to be challenged in a tough but kind way, by using the security of the group.

The uniqueness of the DTC and the structures represented within the model appeared to enhance the mechanisms described. Having a set structure, keeping to time and having specific times to talk helped to create a containing and safe space that was clear to all members. The jobs within the group, which helped to challenge people, were seen as important therapeutically and helped individuals make clear behavioural changes. This operationalised Haigh's (1999) culture of participation. Having a job meant having a role and being a vital part of the group. These jobs empowered individuals and increased confidence in their own skills. Finally, reviews were an important aspect of the group where individuals could reflect on the progress they had made. Without the protected space to do this, participants highlighted that being able to see change and continuing to move forward would be stifled.

Limitations

Due to time limitations of the project it was not feasible to conduct a full grounded theory which may include more participants. Theoretical sampling of participants with different experiences of the DTC model may have added to the results. Individuals who had left the DTC earlier than expected or individuals who had completed the community were not sampled. A process of self-selection may have occurred with members who experienced more positives choosing to opt into the study. Therefore, members who found it more difficult to recognise change may not have opted into the study, but their process in the group may have been different. Additionally, exploring the breadth and details of the mechanisms of change may have impacted on certain aspects of the process being described, with some explored in less detail than others.

The model was developed from the experiences of individuals within the groups and the common processes that were described. This model was created from the narratives of these participants and so other individuals may experience the group and process of change in a different way. Participants were recruited across different therapeutic communities and so the structures of the groups may have differed. Thus, experiences of the DTC model may have been different across participants. Yet, the model reflects a common process and differences across narratives and may incorporate these differing experiences.

Clinical Implications and Future Research

The results indicate a number of considerations for professionals. The start of the DTC was highlighted as potentially increasing an individual's risk. For the main, the group acted to contain this, yet for those who left the group early, this may have increased risk with no place to contain these emotions. Thus, it may be important to have this made explicit when joining. It may be important to ensure that an individual is motivated to join so that the difficult beginning is not experienced unnecessarily, this may already be highlighted in the

process of assessment for the group. However, noting the potential for increased risk and

high dropout rates in similar services (Hummelen et al., 2007), the referring professionals

may need to be aware of these issues in case individuals require help from general mental

health services. Additionally, knowledge that an individual's risk may increase at the

beginning may be important to consider in the group to add a level of containment. It may be

beneficial for groups to include a section within the day's structure to address the difficulties

around joining. The participants highlighted that they were unaware of the group on joining,

even with groups giving out information, therefore different ways of disseminating

information may be important so individuals can make an informed choice. Two of the

DTCs had introductory groups meeting for a couple of hours once a week. Individuals went

to this until they felt ready to apply and their narratives indicated they felt more prepared for

joining the group.

The results also highlight a consideration for clinicians working individually with

service users to consider the use of challenge within sessions. This was seen as a

fundamental difference to 1:1 therapy. It may be that part of a therapeutic contract could be

to consider the use of challenge and how it could be used in an individual context.

Additionally, the use of reviews within therapy may help consider progress and highlight

areas to work on.

The current research highlights a number of areas for future research. The

participants' narratives highlighted the difficult group beginning and the reported number of

individuals dropping out of the group. Research could focus on joining the group, including

the perspective of individuals who remain and those who leave. This may help identify

factors that help individuals remain within the group. Exploring the increase in risk may also

be beneficial in understanding how best to support service users. Similarly, it may be of

benefit to explore individuals' experience of maintaining change after leaving the community

and consider what aspects of the process helped sustain change after leaving.

Conclusion

The process of change within non-residential DTCs was highlighted and explored

with 11 participants. The process indicated the difficult beginning that individuals had to

overcome to be able to use the group to work towards change. Thus commitment was a key

factor. As the individual began to feel more comfortable, the group worked together to be

able to give them a voice which helped individuals share, become known and take on an

identity as a group member. Through being a group member, individuals were involved in a

reciprocal process of giving and taking within the group by using the group for themselves

and being the group for others. Group members challenged each other, offered advice and

shared difficult experiences. Thus an individual acted on both sides of the therapeutic

relationship.

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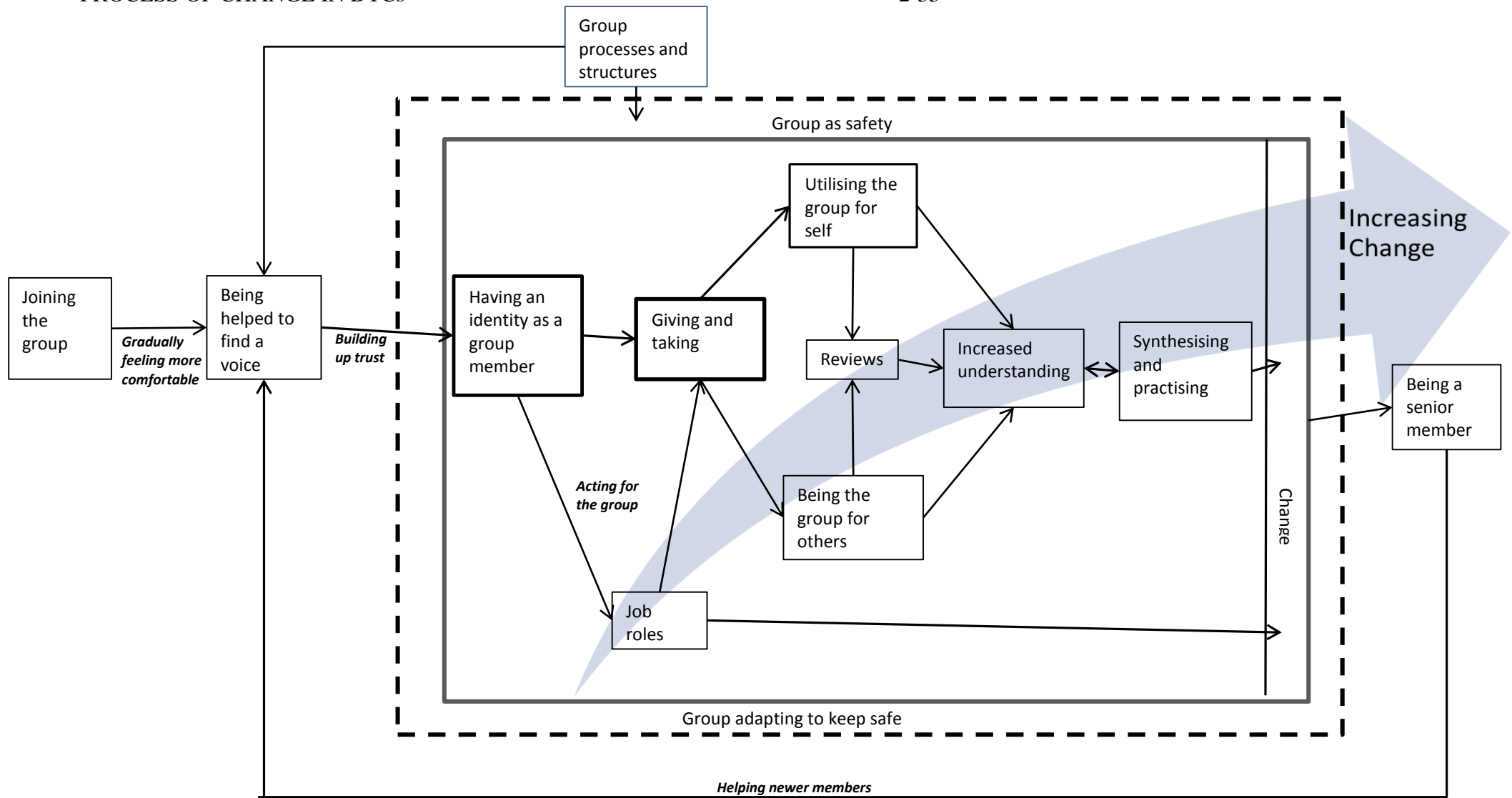
Figure 1. Model of the process of change

Table 1. Participants Demographics

Participant Pseudonym	Length of time in TC	Gender
Jo	13 months	Female
Tony	12 months	Male
Garry	12 months	Male
April	9 months	Female
Megan	17 months	Female
Barbara	18 months	Female
Dee	11 months	Female
Emma	10 months	Female
Cathy	15 months	Female
Andy	12 months	Male
Grace	12 months	Female

Appendix 2-A

Excerpt from transcript-'Jo'

Line No	TEXT	Initial Coding	Focussed Coding
[0:00] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47	I: Can you just tell me a bit about how you came to join the therapeutic community? R: Um, I had a good um psychiatrist who heard about it running up in [place] and they just set one up in [place] and he asked me if I was interested in doing it because I'd done pretty much all the CBT and I've had some 1:1 and I've used um group therapy at [place] Alcohol Services as well erm and he asked me, cos I'd had a bout of depression and what not, if I was interested in maybe attending that. So erm I said yes and I was warned that it might take like three months or whatever to get on it, but I got on quite quickly erm and I started something like October or November last year. I: Mmm huh, and what was it like starting in the therapeutic community? R: Erm, well I freaked out at first because I'd never been to [place] before, so the first hurdle was erm actually getting out the house in the car and going somewhere new and then having to do commit to that every week. So just getting there was a challenge, erm... and then erm going in like a room of complete strangers was weird, but I wasn't too worried about it because I knew everybody had the same sort of diagnosis, if you've got me. But, I went for the interview, erm and that seemed alright and because everybody was allowed to ask questions it wasn't, I had a pre like erm assessment with [psychologist]. Er, two of those and then he invited me for the interview with the group and I did that and then I was lucky enough to get a place and a place came up quite quickly as well. I: Erm, So what was that experience like- having to go to the group erm R: Highly traumatic. Well because they're asking you to do things that pretty much you've already shut down- going new places, getting out in the car or getting on the bus, those things. So just even just committing to get to like the erm just sort of the interviews and everything it's like real really pushing the boundaries to get there. The thing is there is nothing else like it available and when you've been in the system as long as I have you realise that if there's an opportunity like that, you can't screw it up [hmm] because you're probably not going to get the opportunity again. I: So, knowing that there was an opportunity and it was something that not maybe everyone got the opportunity to do kind of helped you get over those barriers and? R: I think so, yeah because there's just nothing else [um huh]. There's you're just left on the back burner otherwise, you know. I: Mmm, huh, ok. And so it sounds like it wasn't kind of easy to start?	Knowledge of group by profs Given choice; Done other options 1:1; group therapy Underlying symptoms Agreeing to attend Getting on it as a task Freaking out at first First hurdle – getting to the group Going somewhere new; committing to go every week; challenging before group Meeting new people Being similar- having same diagnosis? Going for the interview Giving account Feeling lucky to get on Feeling traumatised; being asked to place self outside comfort zone; barriers before start group; practicalities of getting there; committing to get there; Pushing your boundaries Unique opportunity; in the system long-term; recognising importance of the opportunity Knowing there's not much else	Needing other professionals to know about group Getting in group as a task Getting to the group first hurdle Committing to something every week Meeting people with similar diagnosis Going for the interview Being asked to go outside comfort from start Committing to get to interview Seeing importance of taking opportunities Knowing there's nothing else

48 49 50 [0:05] 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100	R: It was really hard [*yeah*], you have to pretty committed just to get to the interviews and stuff, committed to not necessarily getting better but to improving, because I've gone from saying that I want to get better to saying that I realise the best I can hope for is a quality, an improvement in quality in my life because I didn't think they can cure you [*okay*] erm but it teaches you things that make it more bearable to live [*mm huh*] and to function… I: And you mentioned that erm you knew that erm it was something that erm was maybe more specialist or wasn't around for everyone. So did you have a good idea about what a therapeutic community was before? R: No, I had no idea. I had no idea erm apart from the fact that I had took part in group sessions which I found useful at [place] alcohol services [*mmm*]. It had actually, so I'd had like some, I'd learned how to talk in a group which probably helped me a lot, gave me a head start over other people who start, cos sometimes they've never talked in a group at all so they spend the first three months trying to learn to talk in a group. So I had a running start really with that erm but I'd never heard of anything like it except that I read a book by er Marsha Linehan is it? [*mmm*] Linehan on Dialectical Behaviour Therapy or whatever it is because I've been reading around [*yeah*] err like the subject trying to learn things, how to how to get better so I just thought oh, this looks like something like that. I: Mmm, Okay, and what was it like after you joined to group- so you'd had the interview and then you got a place and you went erm, was that bit any easier or was that? R: Well once you know the faces [*mmm huh*] It's okay, but it's so hard work, it's really easy to think this is making my life worse at the beginning because it's opening up all your wounds, you're having to expose yourself completely to get the best out of it, you know, and there's that thing where you worry about other people as well and you have to hear about their traumas and it's really upsetting [*mmm huh*], it's really hard work and I have to say, it takes real commitment [*mmm huh*]. I mean I've seen a lot of people come and drop out either because they just find it too difficult or the, they can't overcome the problems with the transport. [*hmm*]. Erm, or they just find that the painful bit is just too much. It takes a lot of commitment to get through and keep going every week. I: Yeah, so commitment's really important? R: It's really important and it's also hammered home at group that commitment is really important. I: and how is that hammered home? R: Erm, basically by things like time keeping [*mm huh*], because we have a time keeper in the meetings and that helps to install some sort of routine and the fact that there's time boundaries and if you don't renew, you can put your place at jeopardy, if you can't get in because you're sick or something or if you're late, you can be, and if you start, you know, coming some times, not coming others times, there's a system in the group where we can give the person ten minutes extra	Starting group hard; commitment necessary; not going to get better; lowering hopes to realistic expectations Cure not possible Looking for improvements Making life more bearable? Having Limited knowledge Drawing on Previous skills Getting a head start Learning how to talk in a group Reading around the subject Wanting to get better Getting familiar; hard work Making things worse at beg. Opening up wounds Being exposed completely Worrying about others Hearing traumas; upsetting Need for commitment Not for everyone- too difficult Difficulty of just getting there Too painful Surviving each week Need for commitment Group being truthful Commitment as a core requirement of membership Time keeping Routine of the group Jeopardising place if not stick to rules Attending consistently important Group giving extra time suitability	Being committed early on important Lowering expectations from cure to improvement Having limited knowledge of group Learning how to talk in group Reading around subject Getting worse at beginning as opening wounds Needing to expose self to get best Hearing others' traumas Practical difficulties Taking real commitment to get through Informing of real need for commitment Instilling routine through structure Jeopardising place if not adhering Giving someone extra time in suitability

Appendix 2-B

Notes for Authors

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

Submissions
All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at http://mc.manuscriptcentral.com/cjmh . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.
The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

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

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

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

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the Keywords Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

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

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

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:
a) For journal articles (titles of journals should not be abbreviated):

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

Powell, T.J. & Enright, S.J. (1990) Anxiety and Stress management. London: Routledge
c) For chapters within multi-authored books:

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

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.
Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Section Three:

Critical Appraisal: Themes of invisibility

Word Count: 3, 796

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Introduction

Within this thesis, I conducted a literature review exploring staff's experiences of working with individuals with a diagnosis of personality disorder. Within the research paper the process of change within non-residential democratic therapeutic communities (DTC) from the perspective of the service users was explored.

Throughout my experience of conducting my thesis I aimed to retain a critical stance towards the project. As a result, I kept a reflective diary throughout the project to detail and explore the research processes and my thoughts on undertaking this project. Evident across these reflections were themes of invisibility or marginalisation present within my experience of developing the research and within participants' narratives across both papers. The participants who shared their experiences with me described their time within the DTC as being contrasted with their experiences outside of the group. For example, they articulated that people outside of the group were not aware of their difficulties with problems not being visible. It may be that this contrast helped to increase the powerful feeling of connection and belonging for the group members. These themes of invisibility, or being overlooked, will be explored further within this critical appraisal across the different areas of the project, as articulated: "I don't need a cloak to become invisible" (Rowling, 1997, p. 213).

As discussed across the two papers, there have been historical narratives of individuals with a diagnosis of personality disorder being on the outskirts of mental health services, or being excluded due to their presentation (Bateman & Tyrer, 2004). These discourses have reinforced the perceived stigma for individuals with a diagnosis of personality disorder. These experiences were explored from staff's perspectives within the literature review which highlighted that some negative perspectives were still present, despite work to decrease this stigma. These themes of invisibility found across this research project,

which have been documented across service users' narratives of mental health care (Jennings, 1994), may be representative of these historical and continuing discourses.

Choosing a Project

In choosing a topic to explore for my thesis project, I was mindful of my clinical experience as an assistant psychologist within a private medium secure forensic hospital. This health care provision provided secure care to individuals requiring a level of physical and relational security through a high risk of harm to self or others and who had a diagnosis of personality disorder, mental illness or learning disability. My clinical work was based on a dually registered ward for individuals with a diagnosis of mental illness or personality disorder. In my experience, it seemed that a substantial number of individuals were transferred from a prison environment with psychotic experiences and a high level of distress. After these symptoms had reduced it seemed that a lot of individuals were then given a label of personality disorder and detained in hospital rather than being transferred back to prison.

Within my experience of this work, the team did not explicitly develop a psychological understanding of an individual's presentation, thus an understanding of the need or message behind behaviours that challenge was missing. Part of my work involved undertaking file reviews of service users to help inform risk assessments. Through this, I was struck by the number of service users for whom there were reports of trauma or difficulties within childhood. This was my first clinical experience of working with individuals with mental health difficulties and it was through this that I began to critically appraise the models and theories of psychological distress. I came to understand difficulties that may result in a psychiatric diagnostic label as being influenced by socially constructed ideas about what is classed as 'normal' and thus what indicates a deviation from this (Brown, 1995).

Additionally, I saw presentations of mental distress as being linked to experiences of trauma or as a response to difficult situations. For example, behaviours linked with a

diagnosis of personality disorder like interpersonal difficulties could be seen as adaptive and serve a protective function. Thus, for me labelling these behaviours as disordered ignores the past experience of these individuals, the adaptive nature of the behaviours and the societal influences of these labels.

I heard narratives of treatment nihilism discussed within the team and verbalised to service users and so being detained in hospital with a diagnosis of personality disorder appeared to represent a no-win situation. Service users were informed they had to progress to move forward along their care pathway, yet at the same time it was implied that they were not able to change. Through witnessing this discrepancy, I became interested in therapeutic change for individuals with a diagnosis of personality disorder. I entered into a career in clinical psychology with a belief in change and so encountering narratives of un-treatability was a surprise. Thus, I became more interested in therapeutic models of care specifically developed for individuals with a personality disorder diagnosis and how these help to bring about change. Understanding ways in which change can occur appears to be an important aspect of research in order to demonstrate that ideas of treatment nihilism may not be valid.

Furthermore, it seemed that the needs of the individuals and a psychological understanding of their difficulties were largely ignored. In particular, within my experience as an assistant, the power imbalance that existed between staff and service users left the voices of service users ignored and unheard (Miller & McClelland, 2006). I recognised that individual staff could and did take a respectful and compassionate approach, yet there was something about the way the environment and ward was set up which meant that there was an inherent power imbalance (Perlin, 1991). As a result, I became interested in models of care that consider the role of the environment and culture of the ward. I began to learn about the therapeutic community model and was interested in how this model recognised the voices of service users as being equal to those of staff (Whiteley, 2004). Thus, with these experiences,

for my thesis research I wished to explore a model of care that empowered service users and in particular to understand the process of change for these individuals.

Training Course

Narratives of professional training courses not being set up to provide teaching on personality disorder were present across the papers synthesised within the literature review: "basic education and training in relation to BPD was inadequate. They wanted more of it, not only on BPD but also on how to manage themselves" (O'Connell and Dowling, 2013, p.30). This lack of training was seen to impact on the care that individuals could receive: "I felt like I was colluding with him from the start, because I just had so little understanding of personality disorder in general, and there was so little teaching on it" (Millar et al, 2010, pg. 121). Whilst not receiving teaching on all clinical presentations may not provide a barrier for individuals working in specialist services, individuals with a diagnosis of personality disorder have been found to be high users of services including inpatient, community and non-psychiatric provision (Ansell, Sanislow, McGlashan & Grilo, 2007). Therefore individuals working in any sector of care may work with individuals with a diagnosis of personality disorder and without an understanding of the presentation, this may leave the needs of the individual to remain hidden.

The doctorate in clinical psychology is a training course that is set up for trainees to gain transferable skills in working with individuals with mental health difficulties across a range of presentations, level of complexity and clinical environments. Across the course a trainee would gain experience across different sectors of care. Individuals, to a point, could structure their training programme to pursue their clinical interests; for example, an individual interested in working in a physical health context would be able to choose a health placement, receive teaching on this context and undertake research projects. Whilst this was also the case for individuals with an interest in working with individuals with a personality

disorder diagnosis, the level of teaching on this work appeared, at times, to be less than for other areas.

I received teaching on a wide range of topic areas and clinical contexts including working with interpreters, working with asylum seekers, play therapy, and working with transplant patients. These teachings were all interesting and added a breadth to the knowledge I gained on the course, and provided me with transferable skills to work with a range of clinical presentations. Similar to the participants within the literature review, my cohort were keen to access teaching on personality disorder diagnosis and made specific requests for this as part of the third year teaching timetable. In part, I wonder if this reflected my own feelings of anxiety and a wish to feel prepared to work with clients who could be understood to have such a diagnosis. Unfortunately, due to practical reasons, such as teaching being cancelled, my cohort did not receive this teaching. We did however have teaching on therapeutic communities, schema therapy and mentalization based therapy, which provided a more limited opportunity to think critically about the construct of personality disorder. I have wondered if the teaching I received may be reflective of the course's philosophy and ethos around preferring to consider an individual's presentation through understanding a formulation of their difficulties, opposed to focussing on diagnostic labels. Thus, my training has provided me with transferable skills across clinical environments and presentations, the skills to think critically about my work and the narratives present within services. Yet, with more specific teaching, we may have had an opportunity to consider the historical narratives of personality disorder, the debates that still exist around the construct and reflect on how this may impact on service users' experiences of services.

Additionally, in conducting the meta-synthesis and consulting the literature base for the research paper, I was struck by the number of journal articles that I had to request because the university library did not subscribe to the journals in which they were published. This

included the Journal of Personality Disorders, Personality and Mental Health and Mental

Health Review Journal.

Planning the Study

In planning the study it was clear that there was limited research into non-residential

therapeutic communities. Indeed, Lees (1999) comments that although the DTC model has

been around for over 50 years, the research culture has not reflected the influential nature of

the model. A lack of research may act to increase the lack of knowledge about this model,

and thus research is important to enhance the DTC model. Research remains important

within the current financially constrained context of the National Health Service (NHS) as a

way of demonstrating the value of services to commissioners. Without research

demonstrating the power of the model, DTCs may exist with a permanent threat of having

funds withdrawn (Johnstone, 2000). Historically, the DTC model has opposed the idea of

reducing individuals to numbers as per quantitative research and this may have provided

barriers to individuals conducting research (Lees, 1999). For the non-residential DTCs

within the NHS, I could only find the Barr et al. (2010) and the Hodge et al. (2010) papers

which reported the quantitative and qualitative results from the same study into day DTCs. It

may be that other studies have been done, but that they are not readily accessible.

It can be argued that the history of the therapeutic community and its stance as being

different from the traditional model within mental health services may influence the paucity

of research but also keep the groups and therefore service users marginalised within services.

Indeed, structural and systemic elements of the DTC movement may maintain the insularity

of both the model and individual groups and limit their openness to wider professional

networks. The journal 'Therapeutic Communities', which includes research, reviews and

discussion articles about therapeutic communities, much of it conducted by practitioners and

academics linked to the DTC movement, is not subscribed to by many institutions such as

universities, and is thus not widely accessible. The majority of research into DTCs is

published within this journal and so access to the emerging evidence base for the DTC model

is largely restricted to those already working within and around the model, as a result the

movement may remain inward-looking.

Compared with other specialist treatments for personality disorder there is a scarcity

of information available about DTCs. Indeed, most of the participants within the study had

not heard about the group prior to joining it and this appeared to make joining more difficult:

"I just sort of went in blind really" (Garry). Undertaking a search engine exploration into

NHS non-residential therapeutic communities, retrieves no information other than details of

one DTC which had its funding cut just prior to the start of the project. Thus, for people to be

able to do research into therapeutic communities they would need to know professionals

involved. My field supervisor had sent through contact details to the course to act as a

supervisor for thesis projects and through this I was able to attend the therapeutic network

meeting with staff and service user consultant from other DTCs present.

I presented my research proposal at this meeting where I learnt more about the groups

and gauged interest in the research project. One of the themes highlighted at this meeting

was DTC groups struggling with numbers and limited referrals. There was a discussion

about the need for more research and to be able to document the benefits of the group.

However, I wondered whether the scarcity of information may impact negatively on referral

rates into groups and on the amount of research being undertaken. Grace, one of the

participants in the research paper, spoke about how long it took to find out that a group

existed in her area:

> I found out about the group through my mental health worker erm, I'd been referred
>
> to her through the hospital from self-harm and but it was quite a while before she
>
> found out about the DTC, we were on the computer looking for quite a while (Grace).

Thus if the model and groups were more visible, the DTCs may benefit from more referrals.

As part of the research governance process for the project, I applied to four NHS trusts for research and development approval. These departments exist to oversee research projects in their trusts and offer help to individuals running research projects, yet two of these departments were unaware of these groups running in their trust, even after forwarding information about the groups from the trusts' websites; a further illustration of the invisibility of these services.

Conducting the Study

Following ethical approval, I applied to each DTC that had agreed in principle to act as a recruitment site. Each DTC agreed to let me come and visit and every community was extremely welcoming and kind. I found that a number of individuals were really keen to take part in the research and articulated that they were motivated to try and make the groups more visible to try and reduce the stigma they feel and to increase the chance that other individuals would be able to access the group: "I'm treated like I'm an invalid, treated like I'm scrounging off and because nobody is aware of places like DTC" (Andy).

Only one out of the six groups that I recruited from met within NHS premises, with groups meeting in advocacy centres or community centres. I recognise that as the group lasts all day it may be difficult to utilise NHS premises, yet I was surprised that so few of the groups did. This may highlight and reinforce the marginalised status of the DTC within services. However, it may also fit with the ethos of the DTC movement; keeping the groups as separate and distinct from other services may help in strengthening the sense of cohesion within the groups. Indeed, keeping the groups as different may maintain the attractiveness of model to those looking for a different service from traditional psychiatric services (Spandler, 2000). Yet, not having groups meet within NHS premises may also act to keep the groups as

less visible and as 'other', as other service users or professionals would be less able to see the group.

I was privileged to hear the experiences of 11 individuals who were members of different DTCs. Hearing their positive experiences of the groups and the change that they had achieved was powerful to hear. After one interview I found to be particularly powerful, I reflected on the feelings it had evoked for me. This participant spoke in depth about his experience of trauma and of mental health services being inadequate to meet his needs. He had been told that there was nothing that could help him. I felt angry after this interview that this individual's experiences had been ignored, that he had been labelled as 'disordered' as a result of these experiences and that there were still narratives of treatment nihilism embedded in services. He spoke about the DTC, and in particular being "put on suitability" as a powerful moment that gave him a voice. He described suitability as a structure used when a group member was struggling to participate within the group: this involved the individual having a 10 minute space for them to talk. For this participant, this was a powerful moment in the group as it was the first time he had spoken about his past and through this he began to feel connected to the group.

I reflected on the experience of individuals in the group as almost all receiving other forms of therapy prior to joining the group and their opinion on the inadequacy of short term therapies like counselling or CBT: "there's no other options because I wasn't good with one to ones I wasn't good with people at all, so, I think group therapy was the only option what would work" (Megan). This theme was highlighted further by the participants who highlighted the number of services they had accessed before being referred into specialist services: "because it's the last chance saloon, it's the only help that you can see that's out there" (Jo). Davies and Campling (2003) commented in their study of service use following treatment in a therapeutic community that the DTC often represents the last resort option for

service users. All of the participants within the research paper had accessed previous therapy

including counselling and cognitive behavioural therapy (CBT) but spoke about these being

unable to meet their needs and reinforcing that there was something wrong with them:

> I went for about three visits with him, so that's what like 3 months, just like 6 months
>
> and he says I can't do nothing for you, so I said, I said how come, I said other, you
>
> can do things for other people (Tony).

For the participants within the study having short term therapies increased the pressure they

felt to get better. Indeed, six sessions of CBT would be equivalent in time to one day within

the DTC. With the current policy to increase access to psychological therapy this has

increased the number of individuals being offered short-term therapy (Ghosh, 2009).

Whilst I agree that increasing access to psychological therapy is a positive step, six

weeks of therapy for individuals with complex needs may not meet their needs. Whilst there

is a hope that individuals with more complex needs would be referred to specialist services,

this did not happen for these participants until they were referred to the DTCs and may have

reinforced ideas that their needs could not be managed. Campling and Haigh (1999)

comment on the increasing propensity for 'short termism' and the added pressure this creates

for DTCs. Short termism highlights an increase in services that offer the short term gain of

getting individuals through therapy and this being prioritised over longer term approaches.

Yet, the DTC model has been shown to decrease the service use of individuals and has been

estimated to offset the money spent within three years of leaving the service (Davies and

Campling, 2003). This is perhaps unsurprising, as individuals with past experiences of

attachment difficulties may require a longer term therapy in order to form an attachment

within therapy to work towards change (Haigh, 1999).

One of the common themes across participants' stories was the comfort and

connection they felt within the group and the contrast felt with the outside world. The

participants spoke about not feeling safe outside the group, not feeling heard and their difficulties being ignored and not heard: "when you're outside of the group, like not everyone's been abused as a kid so nobody knows how to discuss it and it's all swept under the carpet and like in the group we can talk about it openly" (Emma). This was experienced within mental health services, in participants' families and friends and in other areas of society. Participants spoke about their wish that more people would be aware of the DTC and that more groups would be available. A lot of the participants highlighted that this was a main motivator to take part in the study; to increase the group's visibility and access to others.

I wonder whether the DTC, with it feeling like such a trusting and safe place, was seen as particularly powerful because it was in such contrast to the outside world and other experiences of services. Within the group an individual is visible and the group takes its time to get to know them and see how best they can help. Further, the other group members helped to validate experiences and emotions and helped these difficulties be discussed and brought out into the open. One participant spoke about finally being able to tell people about her trauma without feeling guilty. Thus, it may be that the distinct nature of the DTC, in particular the emphasis on group members providing the main therapeutic input, is useful to group members as it creates a place where individuals belong, have an identity and are able to be themselves: "this, the democratic, you can be yourself" (Dee).

Conclusion

Across my experience of conducting my thesis research was evidence of invisibility and marginalisation for individuals with a diagnosis of personality disorder. Within the narratives of the participants was a perspectives that outside of the DTC and in their experiences of other services their needs and experiences were largely ignored. These narratives may be reflective of the debates around the diagnosis and the utility of mental

health services to help individuals bring about change. These narratives were present across

the research and suggest that more focus may be required to reduce the level of stigma and

marginalisation for individuals with this diagnostic label. Yet, for the participants within the

research paper, the DTC model provided a space and experience where they felt they

belonged and their experiences were validated.

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Section Four: Ethics Documents

The Process of Change in Non-residential Therapeutic Communities

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<u>**Research Protocol-Version 1, 13/08/13**</u>

Research project: The process of change within non-residential therapeutic communities
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Research Supervisor ██
███████████████████   ███
██

Introduction

Historically, the behaviours associated with a diagnosis of personality disorder have

been characterised as being untreatable (Pickersgill, 2013). As a result, provisions for

individuals with this diagnosis have remained a more neglected part of mental health

services (Department of Health, 2003). However, government guidelines have highlighted

the importance of improving the care available to individuals who have received this

diagnostic label (Department of Health, 2003) and have promoted specialist psychologically

based approaches (National Institute for Health and Clinical Excellence [NICE], 2009). The

therapeutic community is a psychosocial intervention for individuals with a personality

disorder diagnosis where members accessing the service are responsible for the decisions

made within the community (Rutter & Crawford, 2005).

The traditional model of the therapeutic community located the provision within

residential or inpatient services. Dolan, Warren and Norton (1997) studied the impact of

attending an inpatient therapeutic community on behaviours characterised as being

associated with a diagnosis of borderline personality disorder through self report

questionnaires. The results demonstrated that, compared to a control group of individuals

who had not accessed the service, there was a significantly greater reduction in the

symptoms associated with a diagnosis of borderline personality disorder. The researchers

highlighted that these results accounted for clinically significant change in 42.9% of the

individuals who had accessed the therapeutic community. In addition, a further study

demonstrated that there were fewer admissions to inpatient services following treatment in

a therapeutic community (Davies & Campling, 2003).

More recently, the therapeutic community model has been adapted for non-

residential settings and is a provision available in the community. Haigh (2007) notes that

the essential elements of the therapeutic community model remain equivalent to that of

the residential services within the non-residential setting. As yet, there has been limited

empirical research into non-residential therapeutic communities. However, the non-

residential therapeutic community may provide a more cost effective way of providing

specialist psychologically based treatment compared with the traditional inpatient services

(Barr et al., 2010). Barr et al. (2010) explored the impact of this model across four one-day a

week non-residential therapeutic communities. The results demonstrated a significant

improvement in measures of mental health and social functioning reflected in both staff and

self report measures.

However, whilst outcome studies can provide valuable information around the utility

of an approach they offer limited insight into how the approach works, or the process that

individuals may go through in achieving change. Hodge et al. (2010) explored the

experiences of individuals attending one day a week non-residential therapeutic

communities. Two themes were developed from the data: 'relating to other people' and

'self harm and risky behaviour'. Overall, the participants' narratives suggested that the

therapeutic community was helpful in addressing some of the behaviours associated with

the diagnosis. This study looked at individuals' general experiences of attending a

therapeutic community. However, Shine and Morris (2000) argue the importance of

developing models of change in helping to understand the distinct nature of the therapeutic

community. To date, no study has specifically examined the process of change within a non-residential therapeutic community from the perspective of the service user. Consequently, the aim of the current project is to explore the process of change experienced by service users within a therapeutic community.

Method

Participants

The pool of potential participants will encompass individuals who are currently accessing a non-residential democratic therapeutic community who have experienced change through the process. It is acknowledged that there are different ways of defining change and therefore knowing if change has occurred. Research into therapeutic communities has utilised various methods of measuring change including a reduction in behaviours associated with the diagnosis, measures of self-harm and measures of change in admissions. In this study change will be defined and determined by the individual, as each individual may have different expectations and goals when accessing the therapeutic community and meaningful change may differ between individuals. Thus individuals' own self-perceptions of having experienced change will be used as the main inclusion criterion.

Participants should have been accessing the therapeutic community for nine months to allow for change to have occurred. Within the research by Dolan et al. (1997) clinically significant change with behavioural symptoms associated with the diagnosis was correlated with increased time in the therapeutic community. A separate study indicated that significant change had occurred around six months in an inpatient treatment setting (Vermote et al., 2009). However, there is limited research for non-residential TC's to determine an appropriate cut off point for recruitment. From consulting with the democratic day therapeutic community network, which is a network designed to increase

communication between therapeutic communities within the North of England, it was decided that nine months may be an appropriate time for individuals to have been engaged within a TC. However, If recruitment proves to be difficult then individuals may be included if they have been accessing the TC for six months and have identified that some change had occurred.

It is hoped that recruitment will take place across a number of therapeutic communities. If recruitment still proves to be difficult then recruitment packs may be sent out to individuals who had previously accessed a therapeutic community and stayed for at least nine months. It is expected that participants will be recruited until data saturation occurs. However, due to the time constraints on the project it is not feasible to have a time open recruitment strategy. Therefore, the upper limit of participants will be 12.

Design and analysis

The project will be qualitative in design, with data being collected through semi-structured interviews. The data will be analysed using adapted grounded theory methodology (Charmaz, 2006). The process will be adapted to take account of the limited timescale and resources for the project. To this aim, recruitment and analysis will take place over two stages. In the initial recruitment stage, six to eight participants will be interviewed and the resulting recordings will be transcribed and analysed by the main researcher to look for emerging themes across the interviews. Within the second recruitment stage the questioning within the interviews will be more focussed on eliciting viewpoints and perspectives around the areas and emerging themes from the initial interviews. The researcher's academic supervisor may listen to a number of the interviews to advise on wording or timing of questions, or to consider how to elicit relevant information within

future interviews. In addition, excerpts of anonymised transcripts may be reviewed by a

group of the researcher's peers to check the accuracy and commonality of the coding.

Materials

A semi-structured interview schedule has been developed. It includes questions and

prompts to help the flow of the interview, though not all questions may be asked. However,

additional questions may be asked if it is necessary to clarify or expand on a point, or follow

a story that the participant raises that is of interest to the research question. In addition,

the schedule for the second set of interviews following the staged recruitment may be

altered to fit with the themes developed in the initial set of interviews.

Procedure

The researcher will follow the procedure outlined by each therapeutic community to

attend the therapeutic community or community meeting or have the research discussed at

the meeting, in order to obtain the verbal consent of the community for participants to be

recruited through it. For instance, this may require the researcher to send a written or

emailed request to the community who will then vote on the request. The researcher may

also attend a therapeutic community to learn about the model and understand the

processes involved. If the community gives its consent, the researcher will then attend the

community meeting or full day to explain the research project to the community and

answer any questions or send through a number of recruitment packs for discussion at the

meeting through staff. Recruitment may happen within the same TC more than once, if this

fits with the time frame of the study. Individuals will be informed that they can opt-in to the

study by returning an opt-in form to the researcher in a provided pre-paid envelope or by

speaking to the researcher following the meeting. Participant information sheets and pre-

paid envelopes will be handed out, or left following the meeting. If recruitment proves to

be difficult then the recruitment packs may be posted by staff supporting the research to

individuals who had previously attended the TC. When an individual opts into the study, an

interview will be arranged at a time that is convenient to them. Interviews may be

conducted in a room at the base for the therapeutic community or at the service base. If

this is not possible then a room in a community setting, like a GP's office, will be accessed.

Prior to the commencement of the interview, participants will be given the opportunity to

read the participant information sheet and asked questions and will be asked to sign the

consent form. The interviews are expected to last between 45 and 90 minutes and will be

recorded with a digital recorder. Following the interviews, the participant will be asked if

they would consent to be interviewed a second time if required, however, they would be

informed that this is voluntary.

Practical concerns

For interviews, travel expenses can be reimbursed up to £10. A digital recorder, foot

pedal, postage paid envelopes and mobile telephone can be supplied by the university.

Photocopying or printing costs will be met by the university.

Ethical Considerations

Participants will be offered the choice of conducting the interviews either at the

therapeutic community or service base if available within the trust or in another community

setting. The interviewer will follow the lone worker guidance of the employing trust. A fully

charged mobile phone will be taken on interviews including emergency contact details in

the speed dial. In addition, a peer of the investigator will be nominated as a buddy. They

will have the full contact details of the researcher. At the time of an interview, the buddy

will be given details of the visit inside a sealed envelope which would only be opened in an

emergency. Following the interview, this envelope will be destroyed. The buddy will also

be given times when contact will be made. The buddy will contact the researcher if they

have not made contact by the agreed time. If contact still cannot be made after 10 minutes

of the buddy trying to contact the researcher then the buddy will contact the police.

Risk to participants

It is possible that participants may experience some distress during the interview;

this will be highlighted within the participant information sheet. However, the questions

will focus on the participants' experience of change and so may not specifically focus on

negative events. The researcher is a trainee clinical psychologist with four years of clinical

experience working with individuals who may experience distress, and of handling

interviews where distress is evident. Any immediate distress would be managed by talking

it through with the participant.

If distress were to occur within the interview then participants would be given the

opportunity to stop the interview. They would be informed of their right to withdraw and

given the option of stopping the interview and withdrawing from the study, arranging the

rest of the interview for another time, or continuing. If participants did experience distress

then they we could talk through their crisis plan. The participants will be engaged with the

therapeutic community and may be advised to use this group to discuss any concerns. It is

recognised that self-harm may be a common aspect of participants' experiences and a

narrative around this may be present within the interviews but that this does not

necessarily indicate a current level of risk. In addition, an individual may have a crisis plan

which they can refer to if distress occurs.

However, it is recognised that individuals do have the potential to become distressed

when talking about their experiences and that this may increase their level of risk. If an

individual expresses current and significant thoughts of self harm or suicide then the level of

risk will be assessed and the appropriate course of action will be agreed between the

participant and the interviewer. In addition the individual may be signposted to resources

highlighted in their crisis plan. If an agreement on the course of action could not be

determined between the participant and the interviewer and the level of risk was

considered to be high then this information may need to be shared with the member of

staff from the TC supporting the research who would then share this with the care co-

ordinator if appropriate. The chief investigator will have the contact details of a member of

NHS staff who works within the TC that the participant is recruited from, in case information

regarding risk does need to be considered. This plan of action around addressing risk within

the study was decided through consultation with the therapeutic community network.

Anonymity and Confidentiality

Any forms containing participants' personal details will be kept in a locked cupboard

at the university. The opt-in forms will be destroyed as soon as the information is no longer

required. The consent forms will be scanned and the paper versions destroyed. The

scanned version will be stored electronically by the university for 10 years from the

submission of the thesis, or in the case that the study is published, after which they will be

destroyed.

Following an interview the digital recording will be transferred to the university's

secure server and deleted from the digital recorder. The transcripts of the interviews will be

anonymised and pseudonyms will be used, any identifiable information will be removed.

The Word files containing the transcripts will be encrypted and password protected and

kept electronically on the university's password protected secure server. The university will

keep the anonymised transcripts electronically for 10 years along with any coded data, after

which they will be destroyed. The researcher will be the custodian of the data until the

project is submitted; the university will then take over the custodianship.

Right to withdraw

Participants have the right to withdraw from the study with no explanation at any

time. After data has been anonymised and analysed it might be more difficult to withdraw

it, though the researcher will make every effort to extract it up to the point of publication.

Timescale

May to July: Apply for ethical approval

July: Apply for R&D approval

August-January: Data collection within a staged recruitment plan

January- February: Data analysis

February- May: Write up and draft reads, submit thesis

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NHS Research Ethics Committee Application Form

NHS REC Form	Reference:	IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Process of change in a non-residential therapeutic community

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product

○ Clinical investigation or other study of a medical device

○ Combined trial of an investigational medicinal product and an investigational medical device

○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

○ Basic science study involving procedures with human participants

○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

◉ Study involving qualitative methods only

○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

○ Study limited to working with data (specific project only)

○ Research tissue bank

○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	◉ No

3. In which countries of the UK will the research sites be located?(Tick all that apply)

☑ England
☐ Scotland
☑ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- ◉ England
- ○ Scotland
- ○ Wales
- ○ Northern Ireland
- ○ This study does not involve the NHS

4. Which review bodies are you applying to?

- ☑ NHS/HSC Research and Development offices
- ☐ Social Care Research Ethics Committee
- ☑ Research Ethics Committee
- ☐ National Information Governance Board for Health and Social Care (NIGB)
- ☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

◉ Yes   ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes   ◉ No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes   ◉ No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

○ Yes   ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes   ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes   ◉ No

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9. Is the study or any part of it being undertaken as an educational project?

◉ Yes   ○ No

Please describe briefly the involvement of the student(s):
The doctoral student will be the chief investigator

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes   ○ No

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10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes   ◉ No

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11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes   ◉ No

NHS REC Form   Reference: IRAS Version 3.5

Integrated Research Application System
Application Form for Research involving qualitative methods only

NHS
Health Research Authority

Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Process of change in a non-residential therapeutic community

Please complete these details after you have booked the REC application for review.

REC Name:

REC Reference Number: **Submission date:**

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

The Process of Change in a Non-residential Therapeutic Community

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Lucy	Morris
Address	Doctorate In Clinical Psychology		
	Furness College		
	Lancaster University, Lancaster		
Post Code	LA1 4YT		
E-mail	l.morris@lancs.ac.uk		
Telephone			
Fax			

Give details of the educational course or degree for which this research is being undertaken:
Name and level of course/ degree:

Date: 4   131681/488750/1/277

Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title Forename/Initials Surname

█ █████   ████
       ███████████████
       ████████
       ████████████
█████ ████████
█████ █████████████

Telephone

Fax

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Lucy Morris	☑ ████████████

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

◉ Student

◯ Academic supervisor

◯ Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Miss Lucy Morris
Post	Trainee Clinical Psychologist
Qualifications	BSc. Psychology MSc. Applied Forensic Psychology
Employer	Lancaster University/Lancashire Care NHS Foundation Trust
Work Address	Doctorate In Clinical Psychology
	Furness College
	Lancaster University, Lancaster
Post Code	LA1 4YT
Work E-mail	l.morris@lancs.ac.uk
* Personal E-mail	l.morris@lancs.ac.uk

Work Telephone   07852515640
* Personal Telephone/Mobile
Fax

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* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.
A copy of a _current CV_ (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname

Address   Research███████

Telephone
Fax

A5-1. Research reference numbers. _Please give any relevant references for your study:_

Applicant's/organisation's own reference number, e.g. R & D (if available):

Sponsor's/protocol number:

Protocol Version: 1

Protocol Date: 13/08/2013

Funder's reference number:

Project website:

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes   ◉ No

Please give brief details and reference numbers.

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. _Please provide a brief summary of the research (maximum 300 words) using language_

easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.

The project would be looking at the process of change in a non-residential therapeutic community. An aim of the project would be to understand how service users experience personal change within a therapeutic community and what about the therapeutic community model helps to maintain these changes. The data would be collected via semi-structured interviews with service users who are attending a therapeutic community and analysed using grounded theory methodology

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Potential participants will be told that continuing to access the TC will not depend on whether they choose to take part in the study; this will be made explicit within the recruitment documents.

At the start of each interview, the researcher will go through the participant information sheet with the participant and answer any questions. The participant will be asked to sign a consent form to demonstrate that they are providing informed consent.

Participants will be able to withdraw from the study at any time. In this case, every effort will be made to remove their data from the results, though due to the type of analysis this may not always be possible after the results have been analysed.

Participants' anonymity will be ensured. Within the interview transcripts any identifiable information will be removed and names will be replaced with pseudonyms. All data from the study will be stored on the university's password protected secure server. Each individual document will be password protected. The digital recordings of the interviews will be transferred on to the university's secure server and deleted off the recorder.

There is a small chance that participants may feel distressed as a result of talking about their experiences. This will be made explicit on the recruitment documents. If distress does occur during the interview then the participant will be reminded that they can stop the process at any point. They will be signposted to resources within their crisis plans if they do become distressed. In addition, if participants highlight that they, or another, are at significant risk then the interviewer will assess the nature of the risk. In this case it may be appropriate to pass this information on to the researcher's supervisor or the staff member of the TC supporting the research.

A6-3. Proportionate review of REC application *The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.*

◯ Yes - proportionate review   ◉ No - review by full REC meeting

Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply.*

☐ Case series/ case note review
☐ Case control
☐ Cohort observation

- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The principal objective for the project is to develop an understanding and explantory theory of the process of change within non-residential therapeutic communities. The project will be looking at service users' experiences of personal change in this setting and what helped change occur and be maintained.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Behaviours associated with a diagnosis of personality disorder have been characterised as being untreatable (Pickersgill, 2013). Yet, government guidelines have highlighted the importance of improving the care available to individuals with this diagnosis (Department of Health, 2003) and have promoted specialist psychologically based approaches (NICE, 2009) including therapeutic communities. The therapeutic community is a psychosocial intervention for individuals who exhibit behaviours associated with a personality disorder diagnosis where members accessing the service are responsible for the decisions made within the community (Rutter & Crawford, 2005). Research has demonstrated that inpatient therapeutic communities can help to bring about change in the behaviours traditionally associated with a personality disorder diagnosis (Dolan, Warren & Norton, 1997). Similar results were demonstrated in a study looking at non-residential therapeutic communities (Barr et al., 2010).
However, whilst outcome studies can provide valuable information around the utility of an approach they offer limited insight into how the approach works, or the process that individuals may go through in achieving change. Shine and Morris (2000) argue the importance of developing models of change in helping to understand the distinct nature of the therapeutic community. However, no study has examined the process of change within a non- residential therapeutic communities from the perspective of the service user.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

The chief investigator will apply to each TC in writing or email requesting to come and discuss the research in the TC meeting. This will be dictated by the preference of the individual TC. The members of the TC will vote on the request. If the request is granted then the chief investigator will attend the TC meeting to discuss the research and hand out recruitment packs, or the members of staff in the TC will present the study and will hand out the recruitment packs. A number of TC's have given permission in principle for recruitment.

Participants will be asked to opt-in by talking to the chief investigator at the meeting, or by returning the opt-in form and pre-paid envelope. When an individual opts in to the study they will be contacted by the researcher to arrange a convenient time and location to do the interview. The interview will be recorded with a digital recorder and should last between 45 and 90 minutes. The interview will take place either at the place where the TC meets, within a service room or in another community setting like a GP's surgery.
At the interview the participant will be asked to read the participant information sheet and will be given an opportunity to ask questions, then they will be asked to sign the consent form. The interview will then take place. Following the interview, the participant will be debriefed. They will be asked if they would consent to be interviewed again, should the need arise, though they will be informed that this may not happen and is voluntary.

Recruitment will take place in three stages. The first stage will recruit individuals who have been accessing a TC for 9 months, and this will take place across a number of TCs. If recruitment proves to be difficult then recruitment will be extended to individuals who have accessed the TC for 6 months. As a result, the same TC may be recruited from on more than one occasion throughout the duration of the study. If recruitment still proves to be difficult then people who had previously accessed a TC may be recruited, this would be done through sending out the recruitment pack through the post. This would be supported by staff supporting the research.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- ☑ Design of the research
- ☐ Management of the research
- ☐ Undertaking the research
- ☐ Analysis of results
- ☐ Dissemination of findings
- ☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
The research has been presented at a proposal day at the university which included service users from the University's public involvement network. The research was also presented at a TC network meeting which included service user consultants who gave feedback on the research. In addition, the recruitment packs and semi-structured interviews were reviewed by service user consultants from the main recruiting trust and changes were made following this.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

The participants should have been attending a non-residential therapeutic community for 9 months, have self-reported experiencing change as a result of attending and be able to give informed consent. If recruitment proves to be difficult then the inclusion criteria will extend to individuals those who have been attending for 6 months, or who have completed the TC within the last 12 months.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

If an individual has not experienced any change, or has not been in the community for at least 6 months.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Reading participant information sheet	1		10	Researcher will gain consent prior to the interview

and signing consent form			
Interview	1-2	60	Researcher will conduct the interview at the base of the TC, a service room or another community location
Debrief	1	10	The researcher will debrief the participant following the interview

A21. How long do you expect each participant to be in the study in total?

The interviews should last between 45 and 90 minutes. Participants may be asked if they consent to being interviewed a second time, but will be informed that this is voluntary and should not be necessary.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Participants will be reimbursed by the university up to £10 for any travel costs in travelling to interviews. There is a small risk that talking about experiences may cause some distress, however this will be made explicit within recruitment documents. Participants will be reminded that they have the right to withdraw from the study at any time. Any distress will be managed in the immediacy by the researcher. However, if the distress or remains then the individual will be signposted to resources in the individual's crisis plan. The researcher will have the contact details of a member of staff from the TC, if any risk issues arise

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

◉ Yes   ○ No

If Yes, please give details of procedures in place to deal with these issues:

There is a small chance that talking about an individual's experience could cause some upset or distress. If distress were to occur within the interview then participants would be given the opportunity to stop the interview. They would be informed of their right to withdraw and given the option of stopping the interview and withdrawing from the study, arranging the rest of the interview for another time, or continuing. If participants did experience distress then they would be encouraged to use resources highlighted in their crisis plans. The participants will be engaged with the therapeutic community and may be advised to use this group to discuss any concerns.

A24. What is the potential for benefit to research participants?

There are no direct benefits to participants

A26. What are the potential risks for the researchers themselves? *(if any)*

The researcher may be conducting interviews in places where there are not many people around. As a result, the employing trust's lone worker policy will be followed

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Potential participants will be identified by requesting and then attending the TC's community meeting. Within the

meeting the study will be discussed and recruitment packs given out.

If recruitment proves to be difficult then recruitment packs may be sent to individuals who had already accessed the TC, and who the team still had the contact details for. Packs would be sent out by NHS staff employed to work in the TC who are supporting the research.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

◉ Yes   ○ No

Please give details below:
Reruitment will be done in three stages. The frist two stages will be done through attending the TC meeting and so no information would be needed. However, if recruitment proves to be difficult then a third recruitment stage may be used. This would involve sending a recruitment pack to indivduals who had completed the TC in the last 12 months. This would be done by staff from the TC supporting the research and would be limited to individuals who had left contact details with the TC.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?

◉ Yes   ○ No

A27-5. Has prior consent been obtained or will it be obtained for access to identifiable personal information?

◉ Yes   ○ No

If Yes, please give details below.

When the individual opts in to the study they will provide relevant personal information to the researcher in order to arrange an interview.

If recruitment gets to the third stage then packs will be sent out to individuals who had completed the TC in the last 12 months. This will be sent out by staff supporting the research, and will be limited to individuals who had left their contact details with the TC.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes   ◉ No

A29. How and by whom will potential participants first be approached?

The researcher will apply in writing or email to attend the TC. The TC will vote on the researcher's request to attend a meeting and discuss the research. From this meeting potential participants will be informed of how they opt-in.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes   ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Individuals will be asked to read the participant information sheet and have the opportunity to answer any questions. The researcher will then ask the participant to sign the consent form.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes   ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will be given the opt-in forms to take home and will be able to opt-in in their own time frame.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Individuals who access the TC will need to speak proficient english to engage within the TC, so it is not expected that an interpreter will be required.

A33-2. What arrangements will you make to comply with the principles of the Welsh Language Act in the provision of information to participants in Wales?

The researcher will take the lead from the TC in Wales and follow the same strategy that they have to comply with the principles of the Welsh Language Act.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

◉ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

If an individual loses consent then their data would be removed from the study where possible

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CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team

☐ Electronic transfer by magnetic or optical media, email or computer networks

☐ Sharing of personal data with other organisations

☐ Export of personal data outside the EEA
☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
☑ Publication of direct quotations from respondents
☐ Publication of data that might allow identification of individuals
☑ Use of audio/visual recording devices
☑ Storage of personal data on any of the following:

    ☐ Manual files including X-rays
    ☐ NHS computers
    ☐ Home or other personal computers
    ☑ University computers
    ☐ Private company computers
    ☐ Laptop computers

Further details:
All data will be stored on the university's password protected secure server, which can be accessed from the researcher's home. With this there will be no need to transport the data on USB sticks. All documents will be password protected. The interview will be recorded on a digital recorder. Following the interview the recording will be transferred on to the university's secure server and deleted off the recorder.
Direct quotations from the interviews will be used, but will be anonymised and reported under pseudonyms. Any identifiable information will be changed or anonymised.
Consent forms and opt-in forms which may contain participant information will be kept in a locked cupboard at the university. Opt-in forms will be destroyed once the information is no longer required. Consent forms will be scanned into electronic forms and kept on the secure server, the paper versions will then be destroyed.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

The transcripts of the interview will be anonymised and a pseudonym will be used for each participant. All identifiable information will be changed or anonymised.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Participants will provide the information required to arrange an interview in the opt-in form to the researcher.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

◉ Less than 3 months
○ 3 – 6 months
○ 6 – 12 months
○ 12 months – 3 years
○ Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

◉ Yes   ○ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Participants will be reimbursed by the university upto £10 for any travel expenses for travelling to interviews.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes   ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes   ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes   ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes   ◉ No

Please give details, or justify if not registering the research.
No relevant database exists

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☑ Internal report
☑ Conference presentation
☐ Publication on website
☐ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☑ Other (please specify)
It is hoped that the research will be published in a peer reviewed journal. The research will be submitted to the

university as part of the doctorate in clinical psychology. The research will also be presented at a university presentation day, and may be presented at other settings including the network meeting of the therapeutic communities and at the TC's recruited from if appropriate

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A53. Will you inform participants of the results?

◉ Yes   ○ No

Please give details of how you will inform participants or justify if not doing so.
Participants will be given the opportunity to request a summary of the results

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5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review

☐ Review within a company

☐ Review within a multi-centre research group

☐ Review within the Chief Investigator's institution or host organisation

☑ Review within the research team

☑ Review by educational supervisor

☑ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The proposal was reviewed at a presentation day which included service users, peers and course staff. The research was developed in coordination with a research supervisor and field supervisors. The protocol was also presented and discussed at the day democratic therapeutic community network meeting which included staff and service user consultants from a number of therapeutic communities and their feedback helped to shape the study.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 12
Total international sample size (including UK):
Total in European Economic Area:

Further details:
The recruitment will be up to 12 participants

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The recruitment will stop once data saturation has been reached as per the method of analysis. However, due to the time constraints of the project it is not feasible to have an time open recruitment, and so recruitment will stop at 12 if data saturation has not been reached.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The data will be analysed using grounded theory methodology. From the analysis a explanatory theory will be

developed from the data around the process of change in a therapeutic community.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co–applicants, protocol co–authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

Title Forename/Initials Surname

Fax
Mobile
Work Email

Fax
Mobile
Work Email

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status: ○ NHS or HSC care organisation   Commercial status:
         ◉ Academic
         ○ Pharmaceutical industry
         ○ Medical device industry
         ○ Local Authority
         ○ Other social care provider (including voluntary sector or private organisation)
         ○ Other

If Other, please specify:

Contact person

Name of organisation ███████████

████████   ██████
███████   ██████
███████   █████████
██████   ████████
██████   ██████

Country

Telephone

Fax

E-mail

Is the sponsor based outside the UK?
○ Yes   ◉ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress

☑ No application for external funding will be made

What type of research project is this?

◉ Standalone project

○ Project that is part of a programme grant

○ Project that is part of a Centre grant

○ Project that is part of a fellowship/ personal award/ research training award

○ Other

Other – please state:

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes   ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname

NHS REC Form   Reference: IRAS Version 3.5

Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

---

A69-1. How long do you expect the study to last in the UK?

Planned start date: 02/09/2013
Planned end date: 16/05/2014
Total duration:

Years: 0 Months: 8 Days: 15

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☑ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 8

Does this trial involve countries outside the EU?
☐ Yes   ◉ No

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? *Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:*

☑ NHS organisations in England   7
☑ NHS organisations in Wales   1
☐ NHS organisations in Scotland
☐ HSC organisations in Northern Ireland
☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Social care organisations
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent hospitals
☐ Educational establishments

Date: 18   131681/488750/1/277

☐ Independent research units
☐ Other (give details)

Total UK sites in study: 8

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

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A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the <u>management</u> of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the <u>design</u> of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the <u>conduct</u> of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

NHS REC Form   Reference: IRAS Version 3.5

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site	Investigator/ Collaborator/ Contact
Institution name ██████	██ ██
██████████	███ ██
████ ████	███ ██
██ ██	███ ███
Institution name ██████	██
███████████	███
████ ████	███ ██
██ ██	███ ███
Institution name ████████	██
█████████	███
████ ████	███ ██
██ ██	███ ███
██ ██	
Institution name ██████	██
██████	███
███ ████	███ ██
██ ████	███ ██
██ ██	
Institution name ███████	██
████████	███ ██
██	███ ██
██	
███ ███	██
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███ ███	███ ██
██ ██	███
██ ██	

Date: 20   131681/488750/1/277

NHS REC Form   Reference: IRAS Version 3.5

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.

4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.

5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.

6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.

7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.

8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.

9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

   - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
   - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
   - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
   - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
   - May be sent by email to REC members.

10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication(Not applicable for R&D Forms)

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

◉ Chief Investigator

◯ Sponsor

◯ Study co-ordinator
◯ Student
◯ Other – please give details
◯ None

Access to application for training purposes *(Not applicable for R&D Forms)*
Optional – please tick as appropriate:

☑ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: --

Print Name: Lucy Morris

Date: 13/08/2013   *(dd/mm/yyyy)*

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature: ....

Print Name:

Post:

Organisation:

Date: (dd/mm/yyyy)

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature: ....

Print Name:

Post:

Organisation:

Date: *(dd/mm/yyyy)*

NHS Site Specific Information Form

NHS SSI   IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Process of change in non-residential therapeutic communities

1. Is your project research?

◉ Yes   ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product

○ Clinical investigation or other study of a medical device

○ Combined trial of an investigational medicinal product and an investigational medical device

○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

○ Basic science study involving procedures with human participants

○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

◉ Study involving qualitative methods only

○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

○ Study limited to working with data (specific project only)

○ Research tissue bank

○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?   ○ Yes   ◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?   ○ Yes   ◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?   ○ Yes   ◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland
☑ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

◉ Yes   ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes   ◉ No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes   ◉ No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

○ Yes   ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes   ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes   ◉ No

---

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes   ○ No

Please describe briefly the involvement of the student(s):
The doctoral student will be the chief investigator

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes   ○ No

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10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes   ◉ No

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11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes   ◉ No

Site-Specific Information Form (NHS sites)

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

- ● NHS site
- ○ Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
The Process of Change in a Non-residential Therapeutic Community

Short title: Process of change in non-residential therapeutic communities

Chief Investigator:	Title	Forename/Initials	Surname
	Miss	Lucy	Morris

1-1. Give the name of the NHS organisation responsible for this research site

1-3. In which country is the research site located?

- ● England
- ○ Wales
- ○ Scotland
- ○ Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

- ○ Yes   ● No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?

Select the appropriate title: ○ Principal Investigator
                               ◉ Local Collaborator

Title Forename/Initials Surname

▇▇ ▇▇▇▇▇ ▇▇▇▇

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Mobile

Fax

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
Less than 0.1

b) Does this person hold a current substantive employment contract, Honorary Clinical   ◉ Yes   ○ No
Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS
organisation?

A copy of a current CV for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

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3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

Location	Activity/facilities
1 ▇▇▇▇▇▇▇▇ ▇▇▇▇▇▇	The chief investigator will apply to attend the TC's community meeting. If this application is agreed, the chief investigator will attend and give out recruitment packs. Interviews may take place at the service base. The chief investigator will have the contact details of a staff member in case of significant risk issues
2 ▇▇▇▇▇ ▇▇▇▇▇ ▇▇▇▇▇	The chief investigator will apply to attend the TC's community meeting. If this application is agreed, the chief investigator will attend and give out recruitment packs. Interviews may take place at the service base. The chief investigator will have the contact details of a staff member in case of significant risk issues

---

5. Please give details of all other members of the research team at this site.

---

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes   ◉ No

---

7. What is the proposed local start and end date for the research at this site?

Start date:	01/10/2013
End date:	01/04/2014
Duration (Months):	6

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

Columns 1-4 have been completed with information from A18 as below:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.

2. If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?

3. Average time taken per intervention (minutes, hours or days)

4. Details of who will conduct the procedure, and where it will take place

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Reading participant information sheet and signing consent form	1		10	Researcher will gain consent prior to the interview	
Interview	1-2		60	Researcher will conduct the interview at the base of the TC, a service room or another community location	
Debrief	1		10	The researcher will debrief the participant following the interview	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?

○ Yes   ◉ No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?

---

10. How many research participants/samples is it expected will be recruited/obtained from this site?

It is hoped that 3-4 participants will be recruited from this site

---

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

The chief investigator will apply in writing/via email to attend the TC to discuss the research. If this request is granted the chief investigator will attend the meeting discuss the research and answer any questions. Recruitment packs will then be given out. The chief investigator may recruit from the same TC more than once. If recruitment proves to be difficult then the recruitment packs may be sent to individuals who have completed the TC within the last 12 months who left their contact details.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
Lucy Morris	Trainee Clinical Psychologist- experience of gaining consent for therapy and previous research projects.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

There are contact details for relevant information points on the participant information sheet

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

There are contact details for relevant information points on the participant information sheet

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

No

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

Participants will need a substantial level of English to engage within the TC, therefore it is not expected that a translator or interpreter will be needed.

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

None. The chief investigator will have the contact details of a staff member of the TC who may be contacted in the case of substantial risk being highlighted during the interview process

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

The chief investigator will have the contact details of a member of staff from the TC in case of substantial risk and will direct individuals to resources in the crisis plan. The chief investigator will follow the employing trust's lone worker policy. The chief investigator has clinical experience in managing emotional discomfort in interview settings.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

The project will be supervised by a research supervisor at the university and field supervisors who work within a TC

21. What external funding will be provided for the research at this site?

○ Funded by commercial sponsor

○ Other funding

◉ No external funding

How will the costs of the research be covered?
Costs of photocopying, materials, recruitment packs, a mobile phone and travel expenses of up to £10 will be covered by the university

23. Authorisations required prior to R&D approval

The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs **prior** to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices **prior** to submission may lead to unnecessary delays in the process of this application for NHS research permissions.

Declaration:
☑ **I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.**

Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:
Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

Title Forename/Initials Surname
▬ ▬ ▬

▬ ▬
Work Telephone

Declaration by Principal Investigator or Local Collaborator

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.

2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.

3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.

4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.

5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.

6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.

7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.

8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.

9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.

10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.

11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.

12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator
or Local Collaborator: ....

Print Name: ███████████████

Date:

Appendix 4-A

Covering Letter- Version 1, 13/08/13

Dear Potential Participant,

Within this pack are details of a research study that I am conducting into the process of change within non-residential Therapeutic Communities.   I would be interested in hearing your experience of the Therapeutic Community (TC) and what helped you to make changes in your life. You have been given this pack as you are either a member of a TC or have recently been part of one; I have not had any access to your personal details.

There is a participant information sheet which explains a bit more about the research project and an Opt-In form with a postage paid envelope. If you are interested in taking part in the study then please fill in your details on the form and post it to me, I will then contact you to answer any questions and arrange a time we can meet.

I can also be contacted via the details provided on the participant information sheet.

Thank you for taking the time to read this letter.

Yours Sincerely,

Lucy Morris
Trainee Clinical Psychologist

Appendix 4-B

Participant Information Sheet- Version 2, 29/09/13

The Process of Change in Non-residential Therapeutic Communities

My name is Lucy Morris and I am conducting this research as part of my doctoral studies in clinical psychology at Lancaster University.

What is the study about?
This research is looking at individuals' experience of personal change within therapeutic communities (TCs). I am interested in understanding how change happens for individuals attending a TC and what helps this change be maintained. The research will hopefully help to develop a better understanding of how TCs work and how they can help people. I am a trainee clinical psychologist and this study will also contribute to my doctoral training.

Why I have been asked?
You have been asked to take part because you have been attending a TC. I would like to speak to people who have been in the TC for at least 9 months [to be changed to 6 months should stage 2 of the recruitment strategy need to be deployed] and have experienced some change. I am asking individuals from a number of therapeutic communities.

Do I have to take part?
No, it is up to you whether you take part. If you choose not to take part in the research then this would not impact on you attending the TC. If you did choose to take part, you could change your mind at any time, even after the interview has taken place. Once your data has been anonymised and put into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract what you said, up to the point of publication. If you did wish to change your mind, then just contact me on the details below.

What will I be asked to do?
If you would like to take part then please fill in the opt-in form and send it to me in the envelope or you can speak to me at the community meeting.

I would arrange a time to come and talk to you. The interview would take about an hour and would involve me asking you questions about the TC, how you have found it, and what change you have experienced. I would record the interviews using a digital recorder. The interview could take place either where you meet for the TC or at another place like a doctor's surgery. After the interview is finished I may ask you if you would mind being interviewed again, but this is optional and may not be required.

What will happen to the results?
The results will be written up into a thesis and may be submitted for publication to a journal. This would be anonymous and your name would not be attached to it. The results will also be presented to my peers and staff on the course and may be presented to the TCs involved in the study.

Will my data be confidential?

The information you provide is confidential. The interview recording will be transferred onto a secure computer server and then deleted from the recorder. I will type up the interview into a transcript which will be anonymised and a different name will be used to refer to you. The transcripts will be encrypted and password protected so only I, or my supervisor, can view them. At the end of the study this will be kept on a CD by the university in a locked cabinet for 10 years and then destroyed.

I may use something that you said within the written report; this would use a different name. There are some limits to confidentiality: if you said something that made me think you, or someone else, is at significant risk of harm then I will have to tell someone, like a staff member from the TC. Where possible I will discuss this with you first.

Are there any risks?

There is a risk that talking about your experiences might bring up some distress. If you did feel distressed then you would be able to stop the interview until you felt ok to continue, or finish the interview at that point. We could spend some time talking through what happened to try and reduce your distress. However, if you still felt additional support was needed then I would encourage you to utilise your crisis plan or use the community to talk through the distress.

Are there any benefits to taking part?

There are no direct benefits to taking part, however you may benefit indirectly by contributing to the development of TC services. It is hoped that the results will help inform clinicians and other professionals about TCs, how they can help people and support them to make changes. This would hopefully help other individuals who may benefit from attending a TC by improving the understanding of service users' needs within the TC.

Who has reviewed the study?

██

Where can I obtain further information?

If you have any questions or would like to see a copy of the research protocol then you can contact the main researcher: Lucy Morris, Doctorate in Clinical Psychology, Furness College, Lancaster University, Lancaster, LA1 4YT.   Mobile number: 07852515640

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

██

If you wish to speak to someone outside of Clinical Psychology, you may also contact:

██

Thank you for taking the time to read this information sheet.

Lucy Morris, Trainee Clinical Psychologist, l.morris@lancaster.ac.uk, mobile: 07852515640

Appendix 4-C
Participant Opt-In Form- Version 1, 13/08/13

The Process of Change in Non-residential Therapeutic Communities

I would like to be contacted further about this research project:

Name:……………………………………………………………………………………………………......

Signature:…………………………………………………………………………………………..

Telephone Number:……………………………………………………………….………..

Email:………………………………………………………………………………………………..

Name of TC………………………………………………………………………………………………

Number of months attending the TC………………………………………………………………………

You can return this opt-in form by posting it to me in the envelope provided or you can contact me on the details below:

Lucy Morris
Trainee Clinical Psychologist
Furness College
Lancaster University
Lancaster
LA1 4YT
l.morris@lancaster.ac.uk
Mobile: 07852515640

Thank you.

Appendix 4-D
Consent Form

The Process of Change in Non-residential Therapeutic Communities- Version 1, 13/08/13

Please initial in the box

☐

1. I confirm that I have read and understood the Participant Information Sheet version no.2 dated 29/09/13.

☐

2. I confirm that I have had an opportunity to have any questions answered.

☐

3. I understand that my interview will be recorded and then made into an anonymised written transcript.

☐

4. I understand that I do not have to take part in the study, and that I can withdraw my consent at any time.

☐

5. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.

☐

6. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. I consent to information and quotations from my interview being used in reports, conferences and training events.

☐

7. I understand that any information that I give will remain confidential unless it is thought that there is a risk to myself or others. In this case the researcher investigator may need to share this information with her supervisor or staff from the therapeutic community supporting the research.

☐

8. I understand that sections of my data may be looked at by individuals from Lancaster University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

☐

9. I consent to Lancaster University keeping anonymised written transcripts of the interview for 10 years after the study has finished.

☐

10. I consent to take part in the above study

☐

Name of participant: Signature: Date:

Name of researcher: Signature: Date:

Appendix 4-E

Debrief form

The process of change in non-residential therapeutic communities

Thank you for taking part in the above study. Your participation will hopefully help us understand more about how therapeutic communities help individuals to make changes. I will be looking at what you, and other people said about attending a therapeutic community and seeing if there was a common experience in how people make changes. From this I hope to develop a theory, or explanation of how individuals go through change in a therapeutic community.

If you feel distressed as a result of the study then you may find it useful to speak about it in the next therapeutic community meeting, consult your crisis care plan or speak to your care co-ordinator.

If you would like to receive a summary of the findings please let me know using the details below and I will send you one when the study is completed.

Lucy Morris
Trainee Clinical Psychologist
Furness College
Lancaster University
Lancaster
LA1 4YT
l.morris@lancaster.ac.uk
Mobile: 07852515640

Thank you again for completing the study

Lucy Morris,
Trainee Clinical Psychologist
Lancaster University

Appendix 4-F

Semi Structured Interview Schedule

The schedule may be altered based on feedback following initial interviews. For example, it may be necessary to alter the wording or order of questions. Other questions may be asked within the interview if more detail or additional clarification is required, or if a participant brings up a topic that is relevant to the research question. Additionally, due to the method of analysis the second set of interviews may follow a different schedule, based on themes that develop from the initial set of interviews.

Please note: It may be that not all questions are asked depending on the answers given to other questions.

Demographic Questions:
>*How old are you?*
>*How long have you been in the TC?*

Interview Questions:

General:
Can you describe what happens with the TC?
>*Prompt: What are the key components of the TC?*
How did you come to join the TC?
What was life like before you started in the TC?
What were you hoping for when you started?
How would you describe your time in the TC?
What was it like starting the TC?
>*Was it easy from the beginning?*
>*Why?/why not?*
>*What helped you to continue?*

Change:
What does change mean to you?
Do you think you've changed?
>*In what way?*
>*Prompts:*
>>*Mental health?- mood*
>>*Relationships?*
>>*Self harm?*
How has this change come about?
What helped you make this change?
Who initiated the change?
Who was responsible for the change?
Was there anything specific that helped that process?
Was the change easy?
How did it feel?
What do you think about the change?
How did these changes occur?

Were there times when this change felt harder?
    Why?
Were the changes important to you?
Was there a distinct point when you began to think or behave differently?
        No, how did the change happen?
        Gradually? How did you know when change was achieved?
        Yes, what was this point?

Therapeutic Community:

How did the TC help?
        Why?
        Anything specific that helped?
What helped in the TC?
Do you talk about change in the TC?
How is change described within the TC?
What has been the most helpful? How?
Were there any key events, crises or turning points?
Has anything been unhelpful?
What was difficult about attending the TC?
What was difficult about making the change?
        How did you overcome that?
Are there any parts of the change process that seem particularly significant?
        If so, in what way?
Were there any times that you thought change was not going to happen
        Why?- What happened?
        What helped you to continue?
Had you accessed other therapies before?
How did the TC compare to those experiences?
What felt the most important in helping you to achieve that?
What would you put the change down to?

Moving Forward:

Do you think it has been successful?
What has been key in sustaining this change?
What are your thoughts on life after the TC?
How did you view yourself at the beginning compared to now?
What were your expectations how things could change?
What has helped you maintain this change?
What else do you hope to change?
        What are your plans to bring about this change?
How do you know that attending the TC has been beneficial?
How would you describe how the TC has helped to other people?
Anything else want to mention?

Potential follow up questions

What was that like?
How does that impact on you?
Is that an important thing to have in a service? Why?
Why was that important?
What do you mean by?
Can you say anymore about that?

Appendix 4-G

Letter of Conditional Approval

NHS
Health Research Authority

National Research Ethics Service

26 September 2013

Miss Lucy Morris
Trainee Clinical Psychologist
Lancaster University/Lancashire Care NHS Foundation Trust
Doctorate In Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT

Dear Miss Morris

Study title:	The Process of Change in a Non-residential Therapeutic Community
REC reference:	13/NW/0635
IRAS project ID:	131681

The Research Ethics Committee reviewed the above application at the meeting held on 19 September 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the

Ethical opinion

The Committee referred the question A27-4 of the IRAS NHS REC form, they had thought that the answer to this question should have been 'no'. The Committee asked whether you would access identifiable personal information in order to identify potential participants. You confirmed that you would not. The Committee explained that it is fine that the participant contacts the researcher and provides their information before giving consent.

The Committee asked what a therapeutic community is. You explained that members of a non-residential therapeutic community meet to discuss their issues. They also participate in group therapy sessions, the focus of which changes each week. The community work together on the individual's issues.

A Research Ethics Committee established by the Health Research Authority

The Committee asked how regularly the group meet. You explained that they would meet one day each week.

The Committee asked if the group meet locally, they had noted that there would be £10 travel expenses. You explained that this is the standard amount per each interview from the University.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

The Committee specified the following additional condition:

- Please include the name of the Committee in the Participant Information Sheet. The ▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter	from Lucy Morris	13 August 2013
REC application	131681/488750/1/277	15 August 2013
Protocol	1	13 August 2013
Investigator CV - Lucy Morris		
Investigator CV - ███████████████		
Letter of invitation to participant	1	13 August 2013
Other: Participant Opt-In Form	1	13 August 2013
Participant Information Sheet	1	13 August 2013
Participant Consent Form	1	13 August 2013
Evidence of insurance or indemnity		
Interview Schedules/Topic Guides	1	13 August 2013
Letter from Sponsor	███████████	13 August 2013
Other: Debrief Form	1	13 August 2013

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/NW/0635	Please quote this number on all correspondence

A Research Ethics Committee established by the Health Research Authority

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Appendix 4-H

Final Letter of Approval

NHS
Health Research Authority

National Research Ethics Service

30 September 2013

Miss Lucy Morris
Trainee Clinical Psychologist
Lancaster University/Lancashire Care NHS Foundation Trust
Doctorate In Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT

Dear Miss Morris

Study title:	The Process of Change in a Non-residential Therapeutic Community
REC reference:	13/NW/0635
IRAS project ID:	131681

Thank you for your email of 29 September 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 26 September 2013.

Documents received

The documents received were as follows:

Document	Version	Date
Covering email from Lucy Morris		29 September 2013
Participant Information Sheet	2	29 September 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering Letter	from Lucy Morris	13 August 2013
REC application	131681/488750/1/277	15 August 2013
Protocol	1	13 August 2013

A Research Ethics Committee established by the Health Research Authority

Investigator CV - Lucy Morris		
Investigator CV - ▓▓▓▓▓▓▓▓▓▓		
Letter of invitation to participant	1	13 August 2013
Other: Participant Opt-in Form	1	13 August 2013
Participant Information Sheet	2	29 September 2013
Participant Consent Form	1	13 August 2013
Evidence of Insurance or Indemnity		
Interview Schedules/Topic Guides	1	13 August 2013
Letter from Sponsor	▓▓▓▓▓▓▓▓▓▓	13 August 2013
Other: Debrief Form	1	13 August 2013
Covering Letter	email from Lucy Morris	29 September 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

13/NW/0635	Please quote this number on all correspondence

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Appendix 4-I

Letter of Approval from Research and Development (Trust 1)
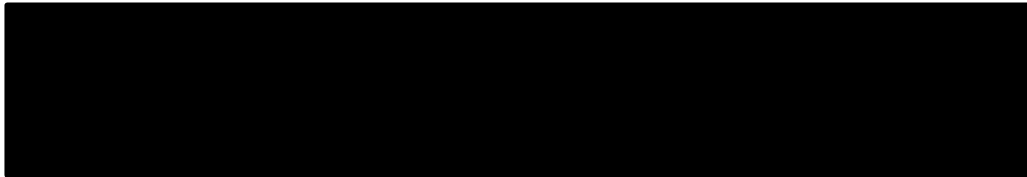
Standardised Process for Electronic Approval of Research

9th October, 2013

Lucy Morris
Furness College
Lancaster University
Lancaster
LA1 4YT

Dear Lucy,

Re: NHS Permission for Research

Project Title: The Process of Change in a Non-residential Therapeutic Community
Unique SPEAR Identifier: 1267
Sponsor: Lancaster University

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research. Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed.

Please take the time to read the attached conditions for NHS permission. Please contact the Research Office should you require any further information. You will need this letter as proof of NHS permission.

NHS permission for the above research has been granted on the basis described in your university application form and supporting documentation.

The documents reviewed were:

- University ethics form
- Participant information sheet v2a and consent form
- Protocol

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the Ethics Committee (where appropriate).

May I wish you every success with your research.

Appendix 4-J

Letter of Approval from Research and Development (Trust 2)

Greater Manchester West **NHS**
Mental Health NHS Foundation Trust

| **Standardised Process for** **Electronic Approval of Research** | Research & Development Office Room F036, Harrop House Bury New Road Prestwich Manchester M25 3BL |

18 November 2013

Miss Lucy Morris
Furness College
Lancaster University
Lancaster
LA1 4YG

Tel: 0161 772 3591/3954/3492/9234
Email: kathryn.harney@gmw.nhs.uk
jennifer.higham@gmw.nhs.uk
sandra.igbodo@gmw.nhs.uk
laura.o'brien-king@gmw.nhs.uk

Information for ID Badge if required:
Research Project Ref No: 802
Expiry Date: 01/04/14

You must take this letter with you.

Dear Miss Morris

Re: NHS Permission for Research

Project Reference: 802
IRAS/REC Reference Number: 13/NW/0635
Sponsor: Lancaster University
Protocol Version and Date: v1 13/08/13
Project Title: Process of change in a non-residential therapeutic community
Date of Permission: 18 November 2013

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research. **Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed.**

Please take the time to read the attached conditions for NHS permission. Please contact the R&D Office should you require any further information. You will need this letter as proof of NHS permission. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

NHS permission for the above research has been granted on the basis described in the IRAS application form, Protocol and supporting documentation.

The documents reviewed were:

Protocol: Version 1 13/08/13
Participant Information Sheet: Version 2 29/09/13
Participant Consent Form: Version 2 17/11/13
REC letter giving favourable ethical opinion: 30/09/13

Greater Manchester West Mental Health NHS Foundation Trust, Trust HQ, Bury New Road, Prestwich, Manchester M25 3BL   Tel 0161 773 9121

Chair: Alan Maden   Chief Executive: Bev Humphrey

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the Ethics Committee [and which have been authorised by the MHRA].

Permission covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. We can confirm that in this instance we will not charge for these. However, we would like to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

May I wish you every success with your research.
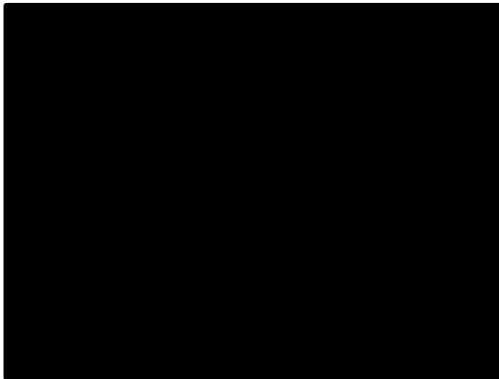
Appendix 4-K

Letter of Approval from Research and Development (Trust 3)

7th November 2013

Miss Lucy Morris
Trainee Clinical Psychologist
Doctorate In Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT

Dear *Miss Morris,*

Re: NHS Trust Permission to Proceed

Project Reference: 13/16

Project Title: *The Process of Change in a Non-residential Therapeutic Community*

I am pleased to inform you that the above project has received research governance permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the trust.

Please make sure that you take your Trust permission letter with you when accessing Trust premises and please include the Trust reference number on any correspondence/emails so that the services are assured permission has been granted.
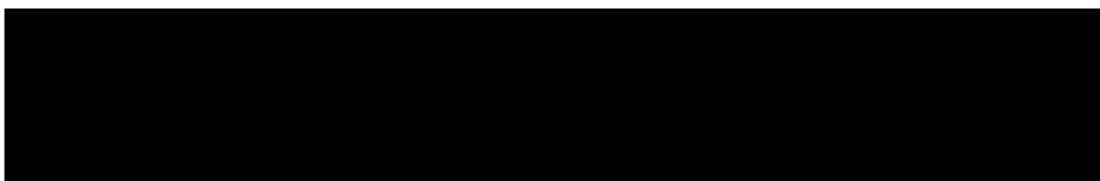
Honorary Research Contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that **directly affects the quality of their care**, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (*Research Governance Framework for Health and Social Care*, 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research <u>MUST</u> be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place

Research Governance

The Research Governance Sponsor for this study is <u>Lancaster University</u>. Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/Publi cationsPolic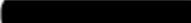yAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.
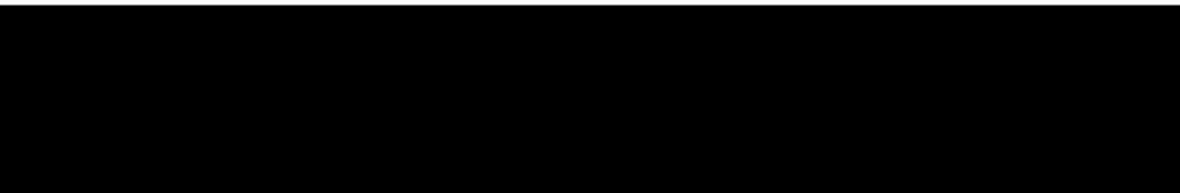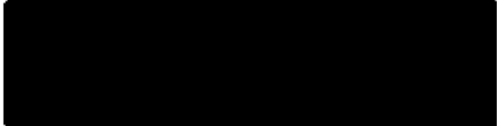
Good Clinical Practice (GCP)

GCP is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. It is the responsibility of all researchers who are carrying out a research project involving NHS patients and carers to complete GCP training and to update this every 2 years. All training certificates must be forwarded to the R&D department to comply with Trust permission. <u>Please note that student projects are exempt from this process.</u>

Risk and Incident Reporting

Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on trust premises, or involve trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within █████████ ██████████ you must adhere to trust policies and procedures at all times.

Confidentiality and Information Governance
All personnel working on this project are bound by a duty of confidentiality. All material accessed in the trust must be treated in accordance with the Data Protection Act (1998) For good practice guidance on information governance contact us.

Protocol / Substantial Amendments
You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Monitoring / Participant Recruitment Details
If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However if your study duration is more than one year, you will be required to complete a short electronic progress report annually and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the trust may withdraw permission.
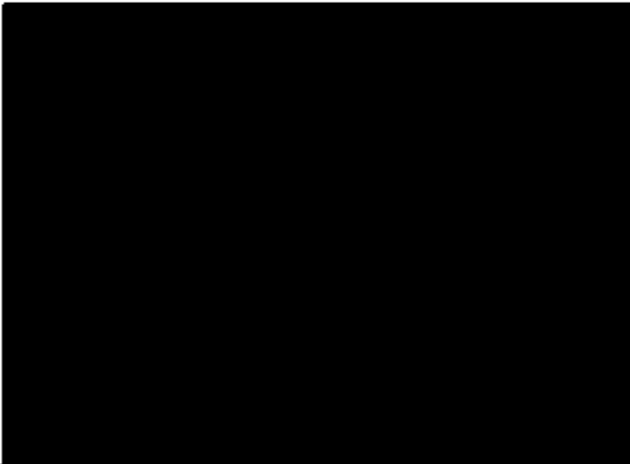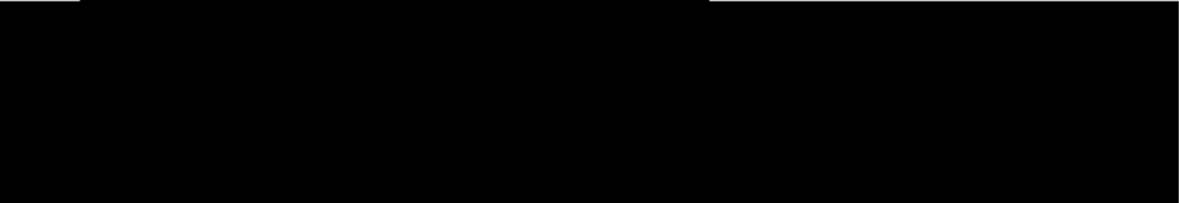
Recruitment
Please provide the trust details of your recruitment numbers when requested. If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Final Reports
At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Appendix 4-L

Letter of Approval from Research and Development (Trust 4)
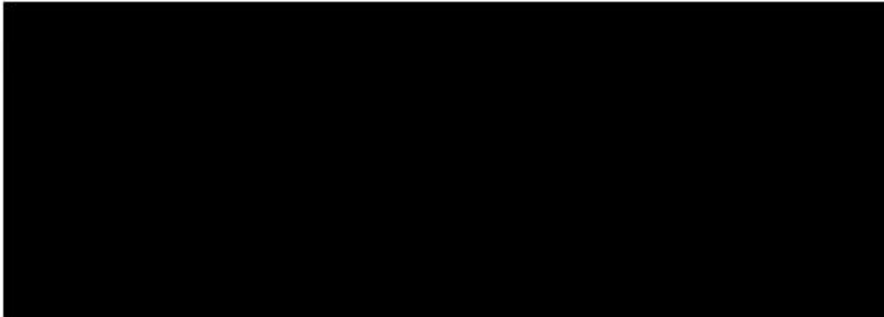
Miss Lucy Morris
Trainee Clinical Psychologist
Lancaster University/Lancashire Care NHS Foundation Trust
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT

Dear Lucy

Research and Development approval letter
Re: Study title: The Process of Change in a Non-residential Therapeutic Community
REC reference: 13/NW/0635   CSP reference: N/A   IRAS reference: 131681

Thank you for submitting your research project for consideration by the Research and Development (R&D) Department. The project was reviewed by the R&D Panel in line with the 'Research Governance Framework for Health and Social Care' and in regards to its impact on resources for the Trust and its suitability within our research portfolio.

We have also verified the relevant documentation and approvals from all necessary regulatory agencies. These may include, but are not limited to, the National Research Ethics Service (NRES), the Medicines and Healthcare products Regulatory Agency (MHRA), and the Administration of Radioactive Substances Advisory Committee (ARSAC).

On this basis, we are now able to grant approval for your project at ███████████████████ subject to the terms and conditions listed below.

- The currently approved protocol is **Version 1 dated 13th August 2013** and the approved documents, including the Participant Information Sheet and Informed Consent Form, are those listed in the Research Ethics Committee's favourable opinion letters for this project dated **30th September 2013**. These must be the only versions in use.

- In the event of any amendment (substantial or minor) to the protocol or documentation, approval must be sought from the necessary regulatory agencies. Approval for the amendment must also be obtained from the Research and Development Department before implementation.

- Any significant deviation from the approved protocol or documentation must be notified to the R&D Department as soon as the issue is discovered.

- The Chief Investigator, local Principal Investigator and all other researchers working on the project must abide by and adhere to their specific responsibilities as detailed in the 'Research Governance Framework for Health and Social Care'. They must also meet all UK statutory requirements, with particular significance, where applicable, to: the 'Data Protection Act 1998', 'The Medicines for Human Use (Clinical Trials) Regulations 2004', the 'Mental Health Act 2007', the 'Human Tissue Act 2004' and all subsequent amendments to these.

- The only researchers approved to perform the research activities for this project at any ████████████ or involving any staff, service users or other persons under our duty of care are those listed on the SSI form and/or delegation log fo ███████

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- All personnel listed on the SSI form and/or delegation log for ███████ must undertake and provide evidence of Good Clinical Practice (GCP) training at least once every two years.

- Recruitment figures for ███████ participants in relation to this project must be sent to the R&D Department on a minimum of a six monthly basis.

- If applicable, the Sponsor or Chief Investigator must notify the R&D Department of any Serious Adverse Events (SAEs) that occur during the conduct of the trial.

- The R&D Department must be notified about any suspension and upon completion of the project, and must be sent a copy of any final report and/or findings.

- ███████ eserves the right to suspend or terminate approval for this project with immediate effect if any of these conditions are breached or in any other circumstances it deems necessary.

- Any further project specific conditions as detailed below:

- The Sponsor's Representative, Chief Investigator and Principal Investigator or Local Collaborator as proof of their agreement to the terms and conditions described above must countersign this letter.

Thank you again for submitting your project to ███████ We wish you good luck with recruitment and with the progress of your project. If you need any further assistance, then please feel free to contact the R&D Department via the contact details at the top of this letter.