



**Crisis Resolution Home Treatment Team Clinicians'
perceptions of using a Recovery Approach with people with
a diagnosis of Borderline Personality Disorder**

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4 **Crisis Resolution Home Treatment Team Clinicians' perceptions of using a Recovery**
5 **Approach with people with a diagnosis of Borderline Personality Disorder**
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28 **Authorship statement.**

29 Each author has made a substantial contribution to the work and is accountable for the work
30 and its presentation.
31
32

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37
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39 **Research Ethics.**

40 This study was approved by the University of Chester, Faculty of Health and Social Care
41 Research Ethics Committee, and the Cheshire and Wirral Partnership NHS Foundation Trust
42 Research Department.
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50 **Abstract**

51
52 Introduction. People with a diagnosis of borderline personality disorder (BPD) are often in
53 contact with mental health services at a point of crisis and in the UK this includes Crisis
54 Resolution Home Treatment teams (CRHTT). There is a drive for services to be recovery
55 orientated, however, there is little evidence about the degree to which community services
56 achieve this for people with a diagnosis of BPD when in crisis.
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3 Research aim. To understand the perceptions held by CRHTT clinicians about their provision
4 of recovery-orientated acute care, for people with a diagnosis of BPD
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7 Method. From a purposive sample of a single CRHTT, seven registered mental health nurses
8 were interviewed and Braun and Clarke's thematic analysis framework was used to interpret
9 the data.
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13 Results: Five themes emerged: person-centred care; the timing is wrong; inconsistent staffing;
14 the risks are too great; and BPD as a label.
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17 Discussion: The results demonstrate tensions between a drive to deliver person-centred care
18 and a range of challenges that inhibit this, with the possibility of re-framing a recovery
19 approach as 'recovery-ready'.
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23 Implications for practice: A whole-systems approach is required to enable a consistent
24 recovery-oriented approach, but research is also needed for brief interventions specific to this
25 context.
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31 **Relevance statement**

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33 This paper examines the experiences of mental health nurses who are working in a type of
34 service that is relatively common in the UK, but currently, there is little known in this context
35 about the mental health nurses' approach to people with a diagnosis of BPD. The paper
36 highlights the need to consider both a whole system approach to recovery but also
37 interventions tailored to specific contexts of services and client groups.
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45 **Accessible summary**

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48 What is known on the subject.

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50 • It is known that people with a diagnosis of borderline personality disorder often
51 experience crises in their mental wellbeing.
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53 • There is little evidence about the approaches of mental health nurses in community-
54 based crisis teams when working with people with a diagnosis of BPD.
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58 What the paper adds to the existing knowledge.
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- This paper highlights that limited resources, work-patterns and issues of stigma present challenges to delivering recovery-oriented care.
- The paper highlights that nurses typically try to navigate the challenges to continue to provide individualised care, though their self-assessment is that this is with mixed success.

What are the implications for practice.

- The findings suggest that support is needed to develop brief interventions specific to teams working with people with a diagnosis of BPD who are at a point of crisis.

Introduction

Mental health provision in the United Kingdom [UK] has undergone a progressive transformation since the 1980s towards increased community-based services and a reduction in inpatient care (The Kings Fund, 2021). This has included the assessment, care and treatment for people in crisis in their own homes and the development of Crisis Resolution Home Treatment Teams [CRHTT] (Lloyd-Evans et al., 2018). The development of CRHTT services was in part a response to the mounting evidence of the iatrogenic impact of inpatient care, including experiences of feeling disempowered, stigmatised and institutionalised (Shepherd, Boardman & Slade, 2008). It also found itself aligned with the increased emphasis on a recovery approach to mental health, which promotes the values of Connectedness, Hope, Identity, Meaningful life and Empowerment [CHIME] (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). Providing assessment and treatment for someone in their own home offers the opportunity to understand the individual in the context of their day-to-day life, to personalise care, enhance contextual resilience and optimise opportunity for self-determination (National

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3 Health Service [NHS], 2016). Further, it may counter the power-dynamics that are more
4 characteristic of hospital care (Dalton-Locke et al., 2021). International support has further
5 validated the concept of recovery within mental health (World Health Organization [WHO],
6 2019) and alongside personal testimonies, has underpinned policy rhetoric and added
7 strength to the recovery approach. The emphasis is no longer on cure but embraces the
8 individualistic journey; advocating collaboration between clinician and service user to develop
9 positive relationships that support engagement in a meaningful life, fostering identity and self-
10 esteem, building emotional resilience and future hope (Mental Health Foundation, 2018). That
11 said, there is evidence in practice of tensions that are typically expressed as differences
12 between a clinical recovery that focuses on pre-determined criteria and symptom reduction
13 and personal recovery that emphasises personal goals and drives (Donald, Duff, Lawrence,
14 Broadbear, & Rao, 2017).

22
23 Research indicates that CRHTT services are well received by service users; optimising the
24 principles of person-centred recovery, whilst also addressing economic pressures by reducing
25 acute bed occupancy (Morant et al., 2017). Though some service users report dissatisfaction
26 at the lack of continuity of care and consistency (Morant et al., 2017; Titheradge & Galea,
27 2019), and resource limitations (Chilma, Morant, Lloyd-Evans & Wackett, 2021). CRHTT
28 nurses have also reported relative high levels of job satisfaction, particularly valuing the
29 dynamic and collaborative nature of crisis work (Begum & Riordan, 2016; Gimenez-Diez,
30 Maldonado-Alia, Torrent-Sola, Granel, Bernabeu-Tamayo, 2020). Although, the nature of
31 working with people in crisis also creates challenges associated with therapeutic risk-taking
32 and decision-making (Lombardo et al., 2018; Rhodes & Giles, 2014).

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40 To the authors' knowledge there is no evidence on how the experiences of mental nurses in
41 CRHTTs are differentiated when working with different client groups. This may have particular
42 significance for people with a diagnosis of BPD as there is a history of this service user group
43 disproportionately experiencing stigmatising attitudes (Health Quality Improvement
44 Partnership [HQIP], 2018). There is evidence of a widely held perception amongst clinicians'
45 that people with a diagnosis of BPD have a greater capacity for self-management and self-
46 control than those with a different diagnosis (Dickens, Schoutz & Hallett, 2022). This is linked
47 to tensions within clinical practice, reinforcing negative perceptions and emotions in clinicians
48 and challenging the development of therapeutic relationships (Papthanasiou & Stylianidis,
49 2022) and is aligned to low expectations of service user recovery (McKenzie, Gregory & Hogg,
50 2022). However, this has not characterised all care and there is evidence of mental health
51 nurses also being drawn to working with this clinical group and approaching the work with
52 compassion and hope (Bowen, 2013; Day, Hunt, Cortis-Jones, & Grenyer, 2018).

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3 BPD is a recognised mental health disorder (American Psychiatric Association, 2013) that
4 manifests in the earlier stages of development and is categorised by impulsivity, erratic mood
5 changes, emotional outbreaks, self-image instability, difficulties developing and maintaining
6 stable relationships with others, experiencing feelings of emptiness, experiencing suicidal
7 ideation and engaging in acts of deliberate self-harm. In the UK it has been suggested that
8 2.4% of the population meet the criteria for BPD (Moran, Rooney, Tyrer & Coid, 2016) and
9 that people with a diagnosis of BPD account for 20% to 30% of inpatient and 52% to 70% of
10 outpatient clinical populations (Dale et al., 2017). Evidence suggests that people with a
11 diagnosis of BPD are more frequent users of emergency services than any other mental health
12 diagnostic cohort (Bosanac et al., 2015; Coid et al., 2009) because of their expressed distress
13 and increased risk of self-harm and suicide (HQIP, 2018; NICE, 2015). These frequent
14 episodes of emotional crises (HQIP, 2018) regularly bring service users into contact with
15 CRHTTs and a retrospective study undertaken by HQIP (2018) revealed that 49% of
16 completed suicides by people with a diagnosis of BPD had been referred to CRHTT services
17 in the preceding year. In the context of this high service use Warrender, Bain, Murray and
18 Kennedy (2021) reference that there is a lack of definitive evidence to support specific crisis
19 interventions for this cohort. However, there is evidence that CRHTT interventions have been
20 effective for this cohort (Turhan & Taylor, 2016). Notably, innovations in community-based
21 support for people with a BPD diagnosis, including mobile phone applications, with emerging
22 evidence of strong usability and positive reduction in aversive tension (Prada et al., 2017).

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36 Reports by people with a BPD diagnosis indicate that the qualities that they valued most from
37 services and clinicians in their personal recovery were relational: centring around developing
38 trust, feeling empowered (Flora, 2018), feeling heard (Romeu-Labayen et al., 2020) and
39 feeling that their distress is understood in the context of their lives (McCauley, McKenna,
40 Keeney, McLaughlin, 2020). These therapeutic factors all resonate with the aspirations of a
41 recovery informed approach to care and the potential held within CRHTT services, and
42 evidence indicates that these are the qualities that this group specifically seek at points of
43 crisis (Mulligan, Neil, Johnstone, Morris & Swift, 2022). However, little is known as to the
44 capacity for CRHTTs practitioners to apply the principles of a recovery orientated approach to
45 meet the needs of this group.

51 52 53 **Aims**

- 54
55 1. To understand the perceptions held by CRHTT clinicians about their provision of
56 recovery-orientated care, for service users with a diagnosis of BPD.
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2. To understand the barriers that exist for clinicians that challenge the application of recovery-orientated practice.
3. To understand the opportunities that enable clinicians to apply recovery-orientated practices.

Methodology

Study Design and Sample

A qualitative methodology underpinned the research study. A non-probabilistic purposive sampling method was adopted and facilitated the deliberate selection of participants who possessed lived experiences of delivering acute mental health care to service users with a diagnosis of BPD in a CRHTT service (Parahoo, 2014). Inclusion and exclusion criteria were applied to ensure the selected participants were able to inform the research questions by reflecting upon their experiences of delivering care to service users, within a CRHTT setting, for a targeted BPD population. The inclusion criteria that were applied are as follows:

Inclusion Criteria

- Registered mental health nurses working within a CRHTT
- Experience in delivering care to service users with a diagnosis of BPD
- Minimum of twelve months work experience within the CRHTT

It was decided to only include staff with a minimum of twelve months experience within the CRHTT so that the data reflected standard CRHTT practice. This is based upon the evidence of nurses requiring a transition period, when they start in a different professional environment (Feltrin, Newton & Willetts, 2019; Bond, Merriman & Walthall, 2020)

Seven research participants, drawn from a target population of twelve registered nurses were recruited from a CRHTT, located in the northwest of England. The participants were located in a community office base, with the opportunity to operate from several resource centres; the team was multi-disciplinary and comprised of registered and non-registered health professionals.

Participant recruitment was undertaken utilising a gatekeeper, who distributed a blind copied email to all eligible participants within the CRHTT; providing information about the scope and purpose of the research, alongside participant and governance structures. Researcher contact

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3 details were made explicit with an open invitation to contact should further information be
4 required and/or they wished to participate in the study. The researchers also attended the
5 team business meetings to discuss the scope and purpose of the study and to answer any
6 queries as they presented. A poster providing a precis of the research and the researcher
7 contact details was placed in the team office.
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11 **Data Collection**

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14 A semi-structured interview schedule was utilised as the primary data collection tool. The
15 interview schedule comprised eight pre-determined and open-ended questions. Seven
16 interviews were undertaken on a one to one basis. The interviews lasted between 20 and 35
17 minutes and were digitally recorded with consent gained from all participants- see table 1 for
18 participant's demographics. The interviews were conducted in a private room on the work
19 premises of the team, with permission from the host organisation.
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25 Table 1 : Demographic information

28 Gender	29 Six of the seven participants were female. This was expected 30 as those identifying as non-female within the eligible cohort 31 form 14.3%.
32 Age	33 18yrs – 30yrs N = 2 34 35 31yrs – 40yrs N = 3 36 37 41yrs – 50yrs N = 2
38 Years in service	39 5yrs -10yrs N = 3 40 41 10yrs – 20yrs N =3 42 43 >20yrs N = 1
44 Professional registration	45 All participants held a Registered Mental Health Nurse 46 registration.
47 Continuing Professional 48 Development (CPD)	49 Two participants (28.6%) had undertaken a five-day CPD 50 workshop pertaining to knowledge and understanding of 51 Personality Disorder. 52 53 54

Data analysis

Braun and Clarke's (2008) thematic analysis framework was utilised to manage the data as this provided an exhaustive and systematic approach to data reduction and analysis (Creswell & Creswell, 2018). The researchers immersed themselves into the entire data set by actively reading and re-reading the transcribed (verbatim) manuscripts. The six stages of thematic analysis were followed: 1) familiarisation, 2) initial codes, 3) initial themes, 4) review themes, 5) define themes, 6) produce the report. Collective immersion in the data and discursive checking, generated 110 initial codes which on further analysis facilitated the production of 16 initial themes. Thematic refinement was undertaken for the purpose of cohesion, reliability and validity ensuring that it remained congruent with the overall data set (Parahoo, 2014). The researchers produced a map of the codes to facilitate this process as the analysis moved to the identification of the final five themes. Themes and sub-themes were confirmed and labelled, and the essence of the narrative was extracted as per the findings (Silverman, 2014).

Rigour

From the inception of the research design and throughout the researchers were informed by Lincoln and Guba's (1985) criteria of credibility, dependability, confirmability and transferability when assessing the rigour of the research. The credibility of the study was enhanced by two of the researchers having experience of working in CHRTTs, dependability was enhanced by an audit trail of the analysis, confirmability was enhanced by the use of an independent research supervisor during the analysis, and transferability was enhanced through a purposive sample. The researchers who conducted the interviews had existing professional relationships with the research participants; as insider researchers they managed the challenges of risk of influence on participants and of slipping into taken for granted knowledge (Fleming, 2018) through the use of a reflective journal and an independent supervisor. The research team used the 10 item criteria of the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2018) to support the rigour and self-assessed that the rigour of each question was positively met.

Ethics

The research was conducted within the parameters of relevant research governance frameworks (The Health Foundation, 2013) and adherence to organisational and professional safeguarding standards was maintained (Nursing and Midwifery Council, 2018; Royal College of Nursing, 2011). Ethical approval was sought from the supporting university and the NHS Trust. Informed consent was gained before voluntary participant contribution. Participant

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3 confidentiality and anonymity was assured with the allocation of pseudonyms on transcription
4 of the data and subsequent analysis. Information management and storage of personal data
5 complied with the General Data Protection Regulation (2016).
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8 9 **Results**

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11 Thematic analysis revealed five overarching themes, which are outlined below.
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13 14 **1. Person-centred care**

15 All practitioners advocated delivering person-centred care and there was consensus on the
16 aspirational relevance of recovery-orientated practice, aligning with the principles of CHIME,
17 including recognising the need for collaboration and the importance of service user validation
18 and 'connectedness'.
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20 The individualistic nature of recovery and service user needs was referenced throughout;
21 *"focusing on strengths ... working with, not telling or doing"* (P5). Service user empowerment
22 was heralded as a person-centred aspiration; promoting care that *"is very much driven by what*
23 *they want to happen and how they want that delivered"* (P4), whilst facilitating *"being able to*
24 *be autonomous"* (P7). Recovery as a concept was recognised as unique, *"very individualised"*
25 (P4), and was benchmarked by an objective and subjective assessment of a persons' ability
26 to function, with optimisation of this being paramount, in accordance with aspiring to a
27 meaningful life. *"I do think for people to be able to recover ... there has to be an element of*
28 *therapeutic engagement"* (P7), and in the spirit of CHIME, building resilience and autonomy
29 was recognised as positive outcomes of this approach, *"building up the skills to be able to*
30 *seek help in a period of crisis effectively and utilise that effectively"* (P6).
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33 Yet, despite these collective person-centred aspirations, clinical practice tensions were
34 apparent throughout the discourse. Organisational service deficits were recognised as a
35 challenge to the provision of person-centred care and participants referenced the need for
36 'specialist services' and the limitations that their absence posed. As a result, whilst person-
37 centred care as a generic approach was upheld this became challenged if a service user
38 requested care that fell outside of service expectations. One participant, for example,
39 rationalised a pragmatic attempt to manage the expectations of service users in response to
40 the finite service provision, stating that,
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*"I wrote all the things that our team can offer and all the things that our team can't offer
... it helps them to understand the boundaries and realisticness that services can
offer....Our challenges are the expectations of the patient... if they perceive to want*

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3 *something else it can be very difficult to sell or discuss an idea if they've got something*
4 *totally different in their mind that they want" (P6).*
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7 As this participant demonstrates, a clinical skill then becomes how to manage competing
8 expectations within limited resources and maintain a collaborative approach.
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10 11 12 13 **2. The timing is wrong**

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15 Despite a shared view that the service was person-centred in its approach there was a
16 collective view that acute-care was a short-term intervention and therefore typically not
17 designed to deliver recovery-orientated care; *"we don't do recovery; we do short-term crisis*
18 *management"* (P2). The crisis management focus was underpinned by national guidance and
19 local policy (Baugh, Blanchard, Thompson-Sangster & Singh, 2020; Trust, 2017), and
20 embedded within the team culture to a position where it was recounted by all participants to
21 be the sole purpose of their transient involvement in care. Acute-care and recovery were
22 considered *"two very different services"* (P4), operating at *"different paces"* (P5) with recovery
23 requiring *"long-term"* (P1, 4, 5, 6) intervention.
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27 However, there were elements of the crisis management focus that were emphasised and
28 considered congruent with a recovery focus. This included service *"support"* (P3) as being
29 integral to a person's recovery and *"learning from each crisis"* (P6) to be a recovery-orientated
30 outcome and essential to informing *"contingency planning"* (P4). Practical interventions in the
31 form of care plans were promoted as a recovery-orientated approach by most practitioners.
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35 Aside from the limitations of the acute-care criteria, time deficits were reported to impede
36 practitioner engagement in the concept of recovery-orientated practice; *"I don't think we've got*
37 *time"* (P1, 2), *"its quick input, quick intervention, move on"* (P5). A skills deficit was also cited
38 alongside a lack of resources, substantiating the consensus that there was a need to refer on
39 to external services to facilitate the process of recovery, *"our plans are getting somebody back*
40 *to ... where somebody else takes over the recovery approached work"* (P2).
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44 In this context CRHTT input was perceived as the initial stage of a linear recovery process;
45 *"we only start the process we wouldn't complete it"* (P4). Recovery was described as a
46 tangible process; *"it's hard to see sometimes acute-care to recovery"* (P4). CRHTT input was
47 portrayed as being *"one piece of that jigsaw"* (P6) in the context of a journey. A correlation
48 between process and journey was described by most participants (P2, 4, 6, 7) with recovery
49 'readiness' identified as an outcome to crisis intervention, once stability was achieved *"you're*
50 *ready to send them into recovery"* (P2), *"move them on ... it's a process"* (P4).
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3 This was captured by one participant who stated that *"I think we all think that people can*
4 *recover but I don't think that it's our job to do that"* (P5).
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7 **3. Inconsistent staffing**

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10 Additional to the services interim position in relation to community and inpatient services,
11 where there may be more time for a recovery focus, the CRHTT configuration was understood
12 to threaten the development of therapeutic relationships that could underpin a recovery
13 approach. One participant, for example, commented that, *"the main challenges is that different*
14 *practitioners seeing somebody, so they might see somebody different every day"* (P1).
15 Furthermore, this was compounded as *"each practitioner works differently"* (P6), resulting in
16 consistently inconsistent care provision, likened to *"a postcode lottery ... [where outcomes]*
17 *depends on who does the initial assessment"* (P7). The interface with stakeholder services
18 and significant others was seen by several participants to further compound these variances,
19 causing *"conflict and distress for the patient"* (P5) with *"everybody doing different things... We*
20 *need guidance and we're not sure if we're doing the right thing"* (P1). In contrast, however,
21 two participants suggested that the more people involved, the greater the scope for engaging
22 the service user; of matching the 'right' practitioner and optimising the clinical discussion in
23 recognition of the complexities of BPD presentations.
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27 There was a lack of stabilising evidence-based practice elicited throughout the discourse. Its
28 absence appeared to support an experiential hierarchy; *"there may be people within the team*
29 *who have erm more experience and erm they can provide evidence like what's happened in*
30 *the past or they can provide more knowledge erm I guess a lot of the time its opinions"* (P3).
31 This experience appeared to be fortified by opinion; *"I think its opinion, personality, it's a mix*
32 *of things really ... I think experience does come into it but I think it's more opinion"* (P2).
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36 A divergence of opinion emerged, forming two distinct camps with one dominating. There was
37 a repeated perception that some practitioners worked better than others with people with a
38 diagnosis of BPD, with a defining desired quality being the ability to adhere to *"firm boundaries"*
39 (P1, 2, 5, 6, 7). These perceptions were based upon experiential learning, *"my experience... I*
40 *think..."* (P7). Hospital admission was a defining factor that determined a practitioners' worth
41 in the eyes of the majority of CRHTT colleagues, with an admission to an inpatient ward viewed
42 as an undesirable outcome, associated with negative service user outcomes, and an implied
43 failing on the part of the admitting practitioner, e.g. *"it's an option, but it's not an option that I*
44 *personally agree with"* (P7).
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48 The concept of an inpatient admission being a viable option, was perceived by one participant
49 as *"a massive challenge in the team"* (P2), and another participant articulated that, *"I've*
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3 actually found that least restrictive is that 72hr admission, I struggle to relay that in the team”
4 (P3).
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9 10 **4. The risk is too great**

11 There was consensus as to a core priority being the management of risk; *“it’s all about risk*
12 *management”* (P2), predominantly in relation to harm to self and/or others. In relation to
13 people with a diagnosis of BPD, there was a unanimous expression of expected risk,
14 *“somebody with PD ... you link with them self-harming behaviours and they’re not safe”* (P3).
15 It is noteworthy, the use of the abbreviation of *“somebody with PD”*, suggests a lack of
16 knowledge regarding the nuances aligned to the spectrum of personality disorders, rather than
17 specifically BPD. This expectation of risk was reported to subsequently influence the response
18 and expectations of the wider Trust, the response from which has purportedly cascaded down
19 to influence the team ethos and is manifested within individual practice. This was evident in
20 the discussion around the clinical adoption and execution of positive risk management.
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23 A generalist view was offered to describe the collective service perspective and expectations
24 assigned to working with people with a BPD diagnosis; *“a lot of practitioners don’t feel happy*
25 *with supporting people with that diagnosis ... because they are risky, and it scares them”* (P1).
26 This perspective was echoed by all participants.
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29 This shared perspective gave rise to dichotomous practice; there was practitioner recognition
30 of the therapeutic value to positive risk-management and therapeutic service user
31 engagement. Yet, alongside this was an awareness that *“people tend to look at too much of*
32 *a defensive practice with not enough emphasis on therapeutic risk taking”* (P7), and this was
33 attributed to *“fear of consequences ... people don’t take therapeutic risks in the same way”*
34 (P6). Anxieties relating to professional accountability were noted and contextualised by the
35 perception of a wider risk-averse culture.
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38 Furthermore, some identified that service users became clinically and personally defined by
39 their risk status, e.g. *“that becomes their life all of a sudden”* (P3). Practice is influenced by
40 this perception that *“we do spend that time practicing in a recovery-oriented way with other*
41 *diagnoses but this client group we don’t, because we’re literally firefighting and responding to*
42 *that immediate threat to life”* (P5). There was an impetus to move people through the service
43 at pace, due to the nature of acute-care provision and secondly to avert service and
44 professional ‘ownership’ of associated risk events, as *“a lot of people struggle to work with ...*
45 *PD”* (P3) and are eager to refer on, so *“I feel that they’re rushed through”* (P2). As one
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3 participant noted, *"you're practicing defensively ... and that might not be in the patient's best*
4 *interests"* (P5).
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6 7 **5. BPD as a label**

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9 A subtle inference was revealed during the interviews, suggesting that BPD is different in
10 aetiological presentation, genuineness, and trustworthiness than service users with other
11 diagnoses, and as such are viewed through a negative practitioner lens. This is not always
12 an overtly referenced distinction, instead, it revealed itself in the language used, sentence
13 structures and nuances, e.g. *"sometimes we see people who are genuinely really struggling*
14 *(P2); "they might not always be honest ... with people with BPD we're always a lot more*
15 *suspicious"* (P5).
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21 The diagnostic term was noted to evoke a strong, negative response which suggested a
22 potential for countertransference; *"it's a horrible phrase [BPD/EUPD] ... it's a really*
23 *judgemental term"* (P7).
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27 Comparisons were made between BPD and other diagnoses and associated outcomes.
28 Evidence-based interventions were referenced from a bio-medical construct with favourable
29 outcomes, e.g. *"depression ... psychosis ... evidence-based medication we can treat it..."*
30 *(P5), facilitating practitioner optimism and scope for positivity and hope; congruent with*
31 *reciprocity and aligning with CHIME. This was lacking in the BPD prognostic descriptions*
32 *"...but with these people we can't do that"* (P5), there was an acknowledgement of *"a low*
33 *(practitioner) tolerance ... they are very challenging to work with"* (P2), and a sense that
34 practitioners *"struggle"* (P1, 2, 3, 5, 7) to work with this cohort.
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40 It was acknowledged that many service users experience psychiatric co-morbidity, but it was
41 reported that *"people (practitioners) forget ... they just see the label"* (P1), this was further
42 reinforced *"as a team ... we look at the diagnosis rather than the person"* (P3), potentiating a
43 failure to proactively treat a more common mental health presentation. This reflexivity
44 revealed a discreet change in practitioner expectations of the service user and the formation
45 of the therapeutic relationship; *"that then impacts on how we approach not just one patient,*
46 *but the collective patients... with that label, because we've had one bad experience, then we*
47 *tarnish everyone with the same brush"* (P5). The outcome of which subsequently influenced
48 responses; *"staff become burnt out with it, you become frustrated"* (P5).
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55 **Discussion**

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58 This study highlights some of the tensions faced by clinicians in CRHTTs when working with
59 people with a diagnosis of BPD. On the one hand there were a range of factors that participants
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3 identified as challenges to providing recovery-informed care. These included the documented
4 limitations of a service that is organised to have different clinicians on shift on different days,
5 thereby reducing the opportunity to establish a therapeutic relationship (Titheradge & Galea,
6 2019). Also, the context of limited service provision in the wider healthcare system to provide
7 specialist treatment, which is somewhat at odds with reported level of specialist service
8 provision in the UK (Dale et al., 2017). For these clinicians, however, the reality of the local
9 provision evidently did not meet the level of need, hampering the quality of work they could
10 produce at the point of crisis. Furthermore, previous research has highlighted that risk
11 management is an understandable source of tension for clinicians in CRHTTs (Lombardo et
12 al., 2018). This study also indicates that the level of tension appears to be differentiated along
13 the lines of diagnostic groups, and people with a diagnosis of BPD are experienced as a
14 particularly high level of concern for clinicians. Notably, this tension is exacerbated by a sense
15 that there is lack of clarity about evidence-based treatment.
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24 All the factors outlined above contribute to the challenges that nurses experienced in delivering
25 recovery-informed care, and to some extent the tensions come alive most starkly as they
26 intersect with issues of stigma. The study provides evidence of what could be considered as
27 stigmatising attitudes and approaches. For example, comments such as "*with that label,*
28 *because we've had one bad experience, then we tarnish everyone with the same brush*" (P5),
29 suggests a process whereby clinicians struggle to see beyond a diagnostic label, which may
30 then influence their behaviour. Or comments, such as "*a lot of practitioners don't feel happy*
31 *with supporting people with that diagnosis ... because they are risky, and it scares them*" (P1)
32 suggests that there is a danger of not delivering optimal care because of the perceived level
33 of risk. The latter echoes the evidence of nurses over-estimating the assumed dangerousness
34 of this client group (Dickens et al., 2022). Given the evidence that people with this diagnosis
35 are often aware of the stigma attached (Lamph et al., 2022), it has to be considered that there
36 is a danger that this complex tension of risk-management and labelling will be unconsciously
37 communicated to the service users and negatively impact on their experience of care.
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48 There is a body of evidence of stigmatising attitudes among healthcare professionals,
49 including nurses, towards people with a diagnosis of BPD (Day et al., 2018; Dickens et al.,
50 2022). However, it would be wrong to say that stigmatising attitudes were the dominant
51 characteristics of the work in the CRHTT. The study highlights a far more nuanced approach,
52 which included evidence of nurses being conscious of the wider processes of stigmatisation,
53 e.g. "*it's a really judgemental term*" (P7), and the dangers involved in those processes and
54 how they could be navigated.
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3 These challenges were countered by the drive for individual care and the need for professional
4 “*empathy and understanding*” (P6) and the benefits of seeing the whole person, “*I guess it’s*
5 *knowing the person and having a rapport with them ... actually getting to know the person ...*
6 *rather than the diagnosis*” (P3). This was suggestive of opportunities within the environment
7 for relational progression and the development of therapeutic alliances that reflect the values
8 fundamental to recovery-orientated practice (Donald et al., 2017), which are desired by service
9 users and carers (Morant et al., 2017).
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15 The study suggests that the nexus of navigating the tensions between the challenges and the
16 drives towards recovery-oriented work is re-conceptualising recovery work as ‘recovery-
17 ready’. In the context of a service designed to treat people at the point of crisis for a relatively
18 short period, a concept of working towards being ‘recovery-ready’ may have a closer fit to the
19 experience of CRHTT clinicians. This would place an emphasis on “*learning from each crisis*”
20 (P6), which in turn challenges the preoccupation with risk management. The study suggests
21 that these are green-shoots of working ideas about how to manage the tensions in the work,
22 and that this team struggled to unify around practices that would support this. It could be that
23 the insights from this group of clinicians for a focussed “recovery-ready” intervention, could be
24 allied to other attempts to provide brief psychologically informed interventions to people in
25 crisis. The latter has included brief interventions for people presenting at risk of suicide
26 (McCabe, Garside, Backhouse & Xanthopoulou, 2018; Yardley, McCall, Savage & Newton,
27 2019) and service users in a CRHTT (Mulligan et al., 2022). It seems clear that there is a
28 need for a similar brief intervention, designed specifically for CRHTTs working with people
29 with a diagnosis of BPD to support a ‘recovery-ready’ position, that emphasises how people
30 can ‘*learn from each crisis*’. Whilst this would not address all of the wider challenges, such as
31 limitations on resources and the wider processes of stigmatisation, a ‘recovery-ready’
32 intervention could provide a greater degree of consistency amongst teams that too often rely
33 on cultural norms, often driven by concerns of defensive practice.
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46 **What this study adds to the existing evidence**

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48 This study highlights that whilst CRHTTs view working with people with a diagnosis of BPD to
49 be a common aspect of their job, there are issues around a heightened level of concern
50 relating to risk and a lack of clarity about evidence-based practice that differentiates working
51 with this client group from aggregated findings about CRHTT work (Begum & Riordan, 2016;
52 Gimenez-Diez et al., 2020).
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57 An intermediary position that refocuses the purpose of CRHTT intervention from risk
58 management to ‘recovery readiness’; facilitating a change in dialogue fostering hope and
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3 therapeutic optimism. Notably, conceptual reframing can occur in the absence of 'tension and
4 challenge' resolution.
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10 **Conclusion**

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12 Previous studies highlight nurses' experiences of working in CRHTT services, of developing
13 advanced assessment and risk management skills that emphasise positive-risk taking, which
14 support a recovery approach (Begum & Riordan, 2016; Gimenez-Diez et al., 2020). This study
15 suggests that further work is needed to progress this concept and develop a 'recovery-ready'
16 brief intervention for CRHTT clinicians to work with people with a diagnosis of BPD.
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21 **Implications for clinical practice**

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23 The implications for practice can be helpfully viewed through a narrow lens of CRHTT
24 services. This study supports the existing research which highlights the need to invest in
25 practitioner BPD specific education and training (McCarrick & Irving, 2022) to embed
26 evidence-based, recovery-orientated practice. Robust supervision could support teams to
27 reflectively engage in a dialogue about how to manage the balance of the competing tensions
28 that the study has identified. This could mitigate against the tendency of previous practice
29 patterns determining future decisions. A whole-systems review would be required to facilitate
30 and sustain the full application of recovery-orientated practice (Loader, 2017). This could be
31 facilitated by service-wide adoption of a recovery model such as the Tidal Model, which
32 includes a "transition stage" to support a consistent approach to service users transitioning
33 from one service to another (Cam & Ozturk Turgut, 2019).
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42 Research is needed to develop 'recovery-ready' crisis interventions for the specific context of
43 CRHTTs working with people with a diagnosis of BPD, and to test their efficacy and clinical
44 utility from a recovery-orientated perspective.
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48 **Limitations**

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50 Limitations are acknowledged in the transient nature of the interview data; reflecting
51 perceptions held in the moment (Holloway, 2008); which is subject to influence by the
52 presence of the researcher, the interaction style and the environmental stimuli (Holliday,
53 2016). These were mitigated through the use of an external research supervisor and the use
54 of a reflexive log to enhance objectivity. Finite service resources meant that individuals had
55 to balance study participation and clinical responsibilities, which created time constraints that
56 possibly reduced the duration of some interviews and therefore the data generated. However,
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3 the study accessed a 58.3% response rate so is considered robust in its representation of
4 consensus findings of one service. Transferability of the data is limited by the single locality
5 status and small homogeneous sample (Parahoo, 2014), which is reflective of the nursing
6 cohort but not reflective of the views of the wider multi-disciplinary cohort, or of those who
7 chose not to participate. However, the integration of the findings within the wider literature
8 demonstrates the salience of the findings to wider contexts.
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Appendix 1

Semi-structured interview questions.

1. In your view what does recovery look like?
2. In your view what does a recovery approach look like?
3. Are you able to describe a time or an experience of when you have successfully used recovery orientated practices', within the crisis resolution home treatment team, to persons with a diagnosis of borderline personality disorder.
4. What aspects went well?
What factors influenced this?
Were these factors specific to the situation or could they be broadened out and if so how?
5. What challenges did you encounter?
What factors influenced this?
Were these factors specific to the situation or could they be broadened out and if so how?
6. What are your thoughts in relation to whether acute care provision within the crisis resolution home treatment team lends itself to a recovery orientated approach, to persons' with a diagnosis of borderline personality disorder.
7. If you have worked elsewhere, is this approach different and if so how?
8. Is there anything else that you would like to add?