

Making sense of complexity: a qualitative investigation into forensic learning disability nurses' interpretation of the contribution of personal history to offending behaviour

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Abstract

Background: There is growing recognition that an individual's personal history can be extremely influential in shaping his/her future experience, though there has been limited exploration in the context of learning disability and offending behaviour.

Method: Research questions related to participant interpretation of offending behaviour and individual and service responses. A series of focus groups comprising learning disability forensic nurses were conducted across all secure settings, high, medium and low.

Results: Three themes were produced: interpreting offending behaviour; the impact of personal history; responding therapeutically. The difficulties relating to understanding the relationship between offending behaviour and personal history significantly informed the construction of the most effective therapeutic relationships.

Conclusions: An increased focus on the impact of someone's background might inform nursing as it seeks to deliver care to individuals with increasingly complex needs in a time of service transition.

Accessible Summary

- The role of an individual's personal history is important in influencing his development, especially whether they are likely to offend or engage in violent behaviour
- Learning disability nurses relationships with those with a history of violence or offending will improve with a more informed knowledge of how someone's offending behaviour is related to their background
- People with a learning disability can be supported best when the complexity of their lives is fully understood and properly informs the therapeutic relationship.

Introduction

The role of secure care as a means of addressing the offending and violent behaviour of some people with a learning disability remains a contentious issue, with a current emphasis on reducing hospital beds and continuing to develop community alternatives (NHS England, 2015). The domains suggested as significant in determining whether the system works well relate to effectiveness (length of stay, reoffending, incidents), patient safety (restrictive practices, health), and patient and carer experience (quality of life, satisfaction) (Morrissey et al. 2017). An area that has been given less consideration concerns the factors contributing to an individual with a learning disability committing a criminal act or engaging in significant

violent behaviour, which subsequently results in secure care being considered the correct response. Learning disability nurses have become increasingly aware of the issue of complexity in the backgrounds of those encountering secure services, recognising that personal history, along with conditions such as autism spectrum disorder or borderline personality disorders are questioning the nature of the knowledge base required for effective working with this population (Lovell & Bailey, 2017). There is perhaps an escalating need, therefore, to understand how nurses currently interpret offending behaviour, particularly the ways in which they use knowledge of personal history for therapeutic engagement and relationship development. This study goes some way toward addressing this deficit.

Background

There is a growing body of work revealing extensive evidence for adverse life events in the backgrounds of people with learning disabilities, though the vast majority never go on to offend or experience secure services (Wigham et al., 2011). Adverse life events, in this context, refers to the experience of highly distressing events or situations in early life, which are beyond one's capacity for coping and control (Mayo et al., 2017). They might include emotional, physical or sexual abuse, neglect, assault, bullying, witnessing family or community violence, racist attack, serious accidents or injuries, loss of loved ones, abandonment and separation, though this is not an exclusive list (Wright & Liddle, 2014). The experience of such adverse events is, furthermore, much greater than within the wider population (Hastings et al., 2004), and has significant consequences with regard to compromised health and premature mortality (Brown et al., 2009). Studies of prisons and police custody reveal that people with learning disabilities who experience such environments, and despite the work done since the publication of the Bradley Report (2009), there are many such individuals, very often have significant background of trauma pervading their lives (Underwood et al., 2013). The likelihood, furthermore, of people with a learning disability, and a range of other neurodevelopmental disorders, such as autism, attention deficit hyperactive disorder or foetal alcohol syndrome, experiencing custody and having a background of trauma is significantly higher (Hughes et al., 2012). The same authors draw attention to the link between such experience and later engagement in anti-social behaviour and offending, though, of course, the issue is more complex and the impact varies according to the person.

The reasons that people engage in offending behaviour can be many, though in the context of learning disability some authors argue that there may be difficulties in relation to moral reasoning (McDermott & Langdon, 2016). This argument suggests that there is a deficit in the development of an individual's moral schema, the lack of maturity leading to distorted thought processes and reduced levels of empathy, which result in the increased likelihood of criminal behaviour (Gibbs, 2010). This explanation is not without its critics, however, with some arguing that offenders with learning disabilities tend to have developmentally more mature moral reasoning than non-offenders (Langdon et al., 2011). Other approaches to explaining offending behaviour have focused on biological, sociological and developmental dimensions (Lindsay, Sturmev & Taylor, 2004); each of these make a significant contribution, though there isn't a single approach that has proven dominant. The role of the

learning disability itself complicates examination, since it is fraught with ethical concerns, primarily because of historical lessons around eugenics and the institutional approach to care characterizing the twentieth century (Holland, 2004). This background has created difficult conditions for discussion of the relationship between learning disability and offending behaviour, with recognition that many of this group require separate pathways and services, since the alternative can mean inappropriate custodial care for some (Talbot, 2007), but little progress in exacting analysis of the issue.

The contribution of background factors to an individual's propensity for offending behaviour, especially in the context of elevated levels of violence, has been subject to scrutiny around the diagnosis of schizophrenia and personality disorder (Rylan, 2006). Some researchers argue, though, that there has been too much emphasis placed on dispositional influences, such as gender, ethnicity or diagnosis, and not enough on systemic or environmental influences (Esbec & Echeburua, 2010). This, according to some authors, has resulted in an under-estimation of the role of early traumatic experiences, particularly with regard to how this might influence impulse control ability in later life (Marshall et al., 2016). Similarly, there has been plenty of interest in the role of anger and an individual's previous involvement in violence, and not enough around examining the particular circumstances, such as the location of an incident (Castillo et al., 2018), or the hypersensitivity to touch or noise that may disproportionately affect people with learning disabilities (Lillywhite & Haines, 2010). The significance of the role of specific conditions, however, such as Borderline Personality Disorder (BPD), Autism Spectrum Conditions (ASC) and psychosis, with regard to early life history, should not be under-estimated, with strong evidence that they frequently emerge in the context of traumatic experiences of neglect, abuse and violence (World Health Organisation, 2012). This can therefore help practitioners working in secure services to understand why those with a traumatic history can respond so readily with violence as a means of coping with extremely difficult circumstances (Johnstone et al., 2018).

The role of traumatic background in shaping an individual's relationship with offending behaviour appears to be rich terrain to explore if we are to properly understand how services might develop and practitioner skills be enhanced. Exposure to multiple or prolonged traumatic events appears to have a significant effect on ongoing development, and may include psychological maltreatment, physical and sexual abuse or witnessing domestic violence. The consequences include emotional dysregulation, loss of safety, direction and the ability to detect or respond to danger cues, which invariably adversely impact on adult experience, whether in terms of victimization or as perpetrator (Blumenfeld et al., 2010). There remains, in the context of learning disability, little literature on trauma informed care, whether conceptually or integrated into services (Keeler, 2014). There is growing evidence that the experiences a child has in infancy and childhood determines how the brain parts are integrated and function properly (Nelson, 2011), though the impact on services remains limited primarily because of a lack of knowledge about the effectiveness of trauma informed approaches and the subsequent difficulty in promoting a culture and belief system (National Centre for Trauma-Informed Care, 2011).

THE STUDY

Research Design

A qualitative research design was constructed that promoted the development of group conversation as the most pertinent means of addressing the research questions, which were twofold:

- How do learning disability nurses interpret and respond to service users' offending behaviour?
- What do nurses perceive as the most significant factors relating to service user offending behaviour?

The most effective approach toward addressing these questions revolved around the use of focus groups, which would ensure inclusiveness from all areas of security and support a sample with a diverse range of experience. A self-contained focus groups strategy, furthermore, facilitated the necessary debate and discussion to explore participant perspectives, perhaps otherwise inaccessible (Morgan, 1997), and allowed for rich exploration of the perceptions and beliefs underpinning a particularly nursing perspective (Khan & Manderson, 1992). There was a need to understand how participant thought processes reflected their understanding and interpretation (Kitzinger, 1995), in this case of offending behaviour, which warranted skill and sensitivity from group facilitators in the event of displays of emotion (Wellings et al. 2000).

The focus group method adopted enabled assembly of participants quite quickly, representative of different secure services, and able to contrast experiences and insights with similar service user populations (Greenbaum, 1993). Participants from the high secure service, for example, worked in different clinical areas within the same hospital, but were subject to the same issues around security. The important issue, in terms of facilitation, related to negotiating the tension between directing the discussion and standing back to allow the dynamics to emerge (Noaks & Wincup, 2004). The focus groups all lasted around two hours, which is fairly typical (Liamputtong & Ezzy, 2005), and was generally sufficient for exploring the complexity of the subject (Rabjee, 2004); the comfort of the group was catered for through breaks and refreshments (Krueger & Casey, 2000). This strategy was selected because it was considered the most appropriate to investigate how nurses understood service user complexity, and how it contextualized any relationship between offending behaviour and offender background.

Data collection

Five focus groups were conducted in total, comprising all clinical areas, high security (H - 1), medium (M - 1) and low (L - 3). The hospital facilities were in different locations in the north and north-west of England, primarily statutory though one independent institution was included. Focus groups lasted between 80 minutes and 130 minutes and were facilitated by the primary researcher. The numbers in each group varied between six and eight nurses, with the average being seven. All groups were conducted at the clinical place of work in rooms specifically allocated for the purpose by the senior nurse manager. A digital recording device was used to record the focus groups, which were subsequently transcribed verbatim, a

complicated process because of the nature of the discussion generated, which was often vigorous and occasionally combative. A semi-structured schedule was devised in order to support the discussion, and a number of key areas for discussion devised. These included the nature of the offending behaviour experienced, how practitioners sought to explain such behaviour, the sorts of factors that might be perceived as contributing to the likelihood of offences being committed, and how the secure service framework underpinned the nursing approach.

Participants

There were 35 participants, 18 men and 17 women, the majority of whom (n=32) were learning disability nurses, though some had an additional mental health nursing qualification (n=4) and a few had a background in mental health nursing (n=3) but had gravitated towards caring for this population. Participant characteristics are described in Table 1.

Table 1: Participant characteristics in each area of security

	Focus group number & gender (male M; female F) composition	Age	Qualification	Years of experience
High	6 (M = 4; F = 2)	24 – 62 years	Learning Disability (LD) nursing x 6	1 – 24 (average in high 6)
Medium	8 (M = 5; F = 3)	26 - 58	LD x 7 Mental Health nursing x 1	1 – 18 (average in medium 5)
Low	21 (M = 9; F = 12)	22 - 60	LD x 19 MH x 2	2 – 29 (average in low 9)

Data analysis

Burnard’s comprehensive 14-stage approach to thematic analysis was applied to the focus group data, which initially involved immersion in the data to comprehend its meaning in its entirety (Crabtree & Miller, 1999). This required multiple readings of the transcripts in order, eventually, to discover initial codes and categories. Once these had coagulated around some central ideas, these were shaped and worked, constantly returning to the raw data, in order to produce tangible themes. This approach to the data accentuates flexibility, as well as the potential for allowing for unexpected insights (Braun & Clarke, 2006), and was supported through use of the software package, MAXqda (Kuckartz, 2001), as a means of organising the data and tracking the themes during analysis.

Rigour

The sample was purposive, in that they were all qualified nurses currently employed within low, medium or high secure environments, though they were selected from the different populations through randomization. The focus group interview schedule was constructed specifically to address the two research questions. Data analysis was undertaken by the

researchers, both academics but with a learning disability nursing background, simultaneously but independently, before collaboration to produce the agreed themes, since this improves the breadth and depth of the analysis (Pope, Ziebland & Mays, 2000). During assembly of the themes, reliability was sought through the “degree of consistency with which instances are assigned to the same category” (Hammersley, 1992: 67). The issue of validity was addressed by ensuring the process was undertaken systematically, and also that the content of the focus group discussions was accurately captured in the produced themes (Long & Johnson, 2000).

Ethics

Ethical approval was sought and subsequently obtained from both the University Faculty Ethics Committee and the Integrated Research Application system (IRAS). All participants were provided with information about the research aims, the organisation of the focus groups, that their involvement was voluntary and responses anonymous. Written consent was provided before involvement and pseudonyms subsequently assigned during analysis. Handling of data conformed to the expectations of the Data Protection Act 1998.

Findings

Three themes were generated by the analysis: *interpreting offending behaviour; the impact of personal history; responding therapeutically*, which are explained and a selection of underpinning codes shown in Table 2.

Table 2: production and meanings of themes

Theme	Offending behaviour	Background	Responses
Meaning	Umbrella term comprising mainly interpersonal violence, fire setting, and sex offending, which were usually the more severe the higher the secure setting	Factors in an individual’s personal history, particularly with regard to family relationships and structure, which inform his/her world view	Includes the secure unit status, experience of the criminal justice system, approaches to care and balance struck between security and therapy
Codes	Index offence; variation; sex offending; dangerousness	Neglect; rejection; abandonment; dysfunction; substance misuse	Person-centred; risk; boundaries; therapeutic relationship; quality of life

Interpreting offending behaviour: “I just put it in a box at the back of my head”

The desire to retain a degree of impartiality figured prominently with some participants, who were keen to ensure they were able to work closely with people, be non-judgemental, and focus on the person not the offence committed, the nature of which was both varied and challenging, especially in terms of there being a therapeutic response:

“I don’t think the index offence matters...we deal with the people who have committed some hideous crimes...you just have to ignore what they have done...I think about it in the risk assessment, but you’ve got to be non-judgemental...it’s the person not the crime...I just put it in a box in the back of my head and it stays there till I need to get it out” (H).

Participants occasionally discussed the prolonged and inexorable background experience of some of those they cared for, and how it might contribute to the extreme violence later exhibited. Others pointed to a distorted sense of personal morality, perhaps linked directly to the learning disability, though possibly relating to an entrenched belief in being right:

“His dad sexually abused him when he was a boy, beat his mother up, beat his sister up, called him a faggot, over years and years and years...this chap was in his early-20s and his dad was in the chair and he got a bread knife and he walked up behind him and stuck him in the neck and that was payback for all he’d done...he served seven years in prison” (M).

“They don’t see anything wrong in what they are doing and the cognitive distortions are so entrenched, what they believe is right and it doesn’t matter, or, it was somebody else’s fault, it wasn’t my fault” (L).

The particular type of offending behaviour could be significant, generating several considerations around issues such as degree of dangerousness, determination not to be judgemental or revulsion. One participant, for example, emphasised the contradictory aspect of sex offending, whereby offenders were actually the least likely to cause problem within a secure environment. Others acknowledged the seriousness of the offending behaviour but resolutely defended the need to view through a therapeutic lens, whilst some struggled to such an extent that choosing not to work with such individuals was ultimately the only option:

“They are usually quieter, they are very easy to manage because, of course, there aren’t any opportunities in hospital for sexual offending, other than against the patient...they are the clients who usually cause us the least problems, they are very quiet, if they are on a ward with other people who are aggressive they tend to stay out of the way, they don’t get involved in other people’s arguments, they are compliant, they do their treatment and they don’t cause us many problems” (L).

“It was attempted rape...went down as serious sexual assault...but if you can’t see beyond that information then you can’t form a relationship...the one that was serious sexual assault, he, to this day, will say it was her fault” (L).

“They (colleague) have had to have counselling because (of) his indecent assaults on children...it affected them, and they were really...not nasty to him, but very probably couldn’t work with him” (L).

The impact of personal history: “there is usually a dysfunctional childhood”

The past lives of service users were invariably described in quite graphic terms, with sexual abuse, substance misuse, and extensive neglect constituting key features that frequently

framed individual lives from when they were very young to the present. The consequences of these early experiences included certain behaviours becoming a regular part of someone's life from an early age, usually before adolescence, ongoing difficulties in personal relationships and problems around emotional maturity:

“There has been a lot of sexual abuse, a lot of abuse through alcohol from the parents at an early age, a lot of their parents are...drug takers. There is a lot of neglect there from the outset, there is a lot that are left to fend for themselves from a very young age. I think they are initially failed at home” (M).

“They tend to be from neglected, deprived backgrounds, abusive backgrounds, like physical, sexual, emotional...this person grows up into an adult that's dysfunctional, connections are made wrongly, emotional connections” (M).

The ways that participants interpreted an individual's background varied, but several of them suggested links between the experience of rejection or abuse and the ways in which people would go on to relate to others and the world more generally. The establishment of a solid therapeutic relationship meant understanding very closely someone's behaviour, the way in which they would sabotage a relationship, seemingly arbitrarily, or become dependent to an inordinate degree; the difficulties of working with those with extremely damaged lives:

“...very complicated...a lot of abandonment issues...he does tend to grasp and hold on to you and anything that you can give and as soon as he feels that you're pulling away, he'll throw it all away” (H).

“There's an awful lot of baggage and sometimes it does get drawn in with the therapeutic process...mainly by getting them to acknowledge...this past has happened...because that past is going to bring up hurt and pain that will affect you again in your day to day living now” (H).

Participants provided graphic background information about those they cared for, sometimes describing a familial culture of abusive behaviour, with sex providing a specific focus. There was a strong suggestion of pervasive family dysfunction, individuals from abusive environments, who remained desperate for family contact with their abusers. Participants needed to comprehend the consequences of abusive family environments, the ways in which such backgrounds influenced how people constructed their own reality and the significance of establishing trusting relationships with such individuals:

“...numerous offences with children and indecent exposure...a violent relationship between his mum and his dad and he used to receive abuse from his father...wasn't responsive to anything when we did try anything, but then he still requests to see his dad...they sort of disowned him because of the offences” (L).

“...abusing children...but nine times out of ten they've been abused themselves by their parents, been told to do various things, have intercourse with other children within the family and made to do it, so it's become normal for them” (L).

Responding therapeutically: “still a person centred planning approach”

The physical environment, emphasis on risk and role of therapy structured the overall response to care. The physicality of the environment, for example, reflected in the level of security, revolved around the risk presented, which in turn determined expectations around immediate visibility, facilities, and nursing roles.

“You are much more conscious of what other staff members are doing (in medium secure), and you pick up on body language...on a low secure environment it seems to be far less stressful, people don’t seem to say, where is such and such a person, I haven’t seen him for a few minutes” (M)

“In medium secure...the best quality of life possible in that environment, not taking unnecessary risks...that the staff teams are safe, that other service users are safe...an indoor gymnasium with cardiovascular equipment...a 5-a-side indoor place...all-weather pitch outside” (M).

“There are fewer restrictions on people in low secure provision, whereas with medium secure they would always be escorted wherever they were...they wouldn’t be entrusted to leave the building at all...in low secure people can go to work by themselves, even have something called free time...away from the staff and away from the ward...in some cases to go to (the local village)...maybe go for a walk” (L).

“(High secure)...very high fences, very barren environments, very clinical...and bleeps going off and big staff presence really and you can’t walk so much as ten yards without going through three locked doors...risk assessment...quality of life doesn’t seem to be big on the radar for people, it’s more about managing that person in the safest environment” (M).

The environmental context, however, did not mean that the nursing approach should be different, and participants were keen to emphasise their rights-based credentials:

“General attitudes are pretty much the same wherever you work and you would still want them...to have an attitude that they have to support, to help, to enable people to fulfil their full potential...the best interests of service users would always be at heart” (L).

The importance of establishing a therapeutic relationship was frequently discussed by participants, with issues of trust, degrees of openness and communication skills contextualized by broader issues of observation and knowledge of the individual. Participants discussed the problematic nature of working with risk in secure environments, especially avoiding taking risks and the difficulties inherent in working with a degree of autonomy:

“...you’ve got to be quite good at setting boundaries...be firm, but you’ve got to be fair as well...when a patient is pushing boundaries...it can be very easy to become...too authoritarian, and sometimes you’ve got to step back and...think, okay, maybe I could have handled that in a more patient way...something that comes...as you get to know them, as they get to know you” (L).

“I think (nurses) have become...frightened of getting it wrong, of making a mistake, of there being an incident...I do believe in risk assessments but if you are a thinking nurse who engages the brain there should be scope for interpretation...use your own judgement...to be able to make the right call because you know that individual” (L).

Participants, though more comfortable discussing risk and responding to behaviour or particular incidents, did address the issue of how building a therapeutic relationship necessitated more than acknowledging an individual’s difficult personal history. They discussed the importance of recognising someone’s history, the need for clear and effective communication at the appropriate level, and subsequently assembling a route through secure care that would facilitate individual growth. The significance of the individual’s learning disability was fundamental, since this influenced, not only someone’s understanding of what was happening to them, but also his capacity and motivation for change:

“Part of our role is to acknowledge and validate his experience, say okay that’s happened, this is who you are...we have to work with him to acknowledge the risk...we need to change some of that risky behaviour...look at issues like motivation...identify the things he needs to change and then we can put him on the forensic treatment pathway...we have to do that in such a way that he’s able to understand it...and that’s the difficult bit...we have to get across that they only move on if they can demonstrate that the risk is reduced, not like prison where every day is a day off your sentence and that’s sometimes hard for these guys to accept, but once they accept that, they do work very well” (H).

The role of therapy and establishing a therapeutic relationship were not straightforward, however, and though it was important to integrate anger control, the adapted sex offender programme and mindfulness-based approaches into the overall care package, there were always consequences, sometimes in terms of treatment resistance but more often relating to how to use an individual’s personal history and offending behaviour as a way to achieve personal growth:

“I do have people who are completely treatment resistant...I am not going to accept any of the treatment you give me and when I leave I will do exactly the same thing again, I have got two men who have both said that” (L).

“A number of our patients are left very traumatized because of the offences that they’ve committed and one thing that we do...I won’t say that it’s done consciously, but they constantly have to replay all the negative things about their past, their offending, the trauma that goes with that and we invariably, I think, traumatize patients as part of our treatment” (H).

Discussion

The therapeutic context of secure care has been subject to debate over many years, with a general acceptance that the level of dangerousness requires that people are protected, whilst simultaneously acknowledging the importance of effective treatment. The significance of

personal history, however, has never fully been understood in terms of this security-therapy dichotomy, and this has clear implications for how we determine whether responses to offending behaviour are likely to be effective. The important element for nurses caring for people with learning disabilities and an offending background, besides a comprehensive understanding of the nature of learning disability (or perhaps because of it), was the overwhelming knowledge around service user personal background. It was this factor that was decisive in shaping learning disability nursing in secure settings, the combination of a history of neglect and/or abuse together with an understanding of how the learning disability influences one's relationship with others. Knowledge assimilation is critical to our understanding of how best to communicate with others and make effective decisions (Lovell et al., 2014). The nature of such knowledge, however, is sometimes difficult to clearly articulate, but must begin with the learning disability and how it relates to issues such as the manifestation of violent and/or offending behaviour. This is not simply with regard to the way in which information is processed and understood, and how poor choices might be made, but more complex concerns such as how the learning disability interrelates with a personal background that is often difficult to fully comprehend. The relationship between learning disability and offending behaviour is complicated by additional, sometimes multiple, diagnoses, particularly BPD and ASC, but many others besides. The difficulty, of course, is understanding how these factors interrelate and are influenced by personal history, since it is in understanding such complexity that we might seek to make important progress in engaging with this group (Lovell, 2017). This is especially the case in relation to non-institutional settings, since this is the anticipated direction of services for the foreseeable future.

The final theme related to the roles of physical security, risk, and the therapeutic relationship, all of which dominated participant discussion relating to responding to people with learning disabilities and an offending background. The central tension characterizing secure environments was very evident, and the degree of security could not be dismissed. The establishment of the therapeutic relationship cannot be detached from the secure context, and the way it is developed in conjunction with its primary characteristics is coloured by the level of security. The issue of establishing boundaries, for example, together with observation skills, though central to working with offenders with learning disabilities, regardless of security level, was considered more pertinent as the security increased. The difficulty appears to relate to the dialogue between these two elements, therapy, based on recognition of the role of traumatic background shaping an individual's life and subsequent decisions, and security, with its inevitable emphasis on restricting movement and simplifying care around the management of risk. The therapeutic dimensions of relationship-building, understanding body language and ensuring care is person centred become subsumed within the needs of security. In effect, the issue becomes about quality of life, which, to some degree, challenges therapy as the way in which progressive care can be achieved within secure settings. Quality of life facilitates a particular approach to secure care, which is person centred and allows for good relationships between nurses and service users. Establishing the relationship as therapeutic, however, is more problematic, and at some point compromises the individual's growth and possibilities around moving forward when outside of secure care.

The future of care for people with a learning disability and an offending background is outside of secure settings, though such hospital provision will continue to play a role; so, it is in facilitating their lives outside of hospital that nurses need to become more skilled. Knowledge of the impact of an individual's background, particularly the complicated role of trauma, is central to this imperative. Nurses need to be aware that the structure and functioning of the brain is altered following exposure to significant trauma (Bremner, 2002), and the consequence can be significant impairment in mood and behaviour regulation resulting in subsequent maturational difficulties, such as inability to establish effective interpersonal relationships, regulate emotions and learn from experiences (Schore, 2003). If sustained positive experiences can help reverse neural pathway discrepancies and help the brain compensate for deficits (Citri & Malenta, 2008), then this has to be central to our understanding of how the therapeutic relationship should develop in supporting individuals to flourish in community settings.

Limitations

The research encompassed all areas of security but findings reflect only the views of those participating and not the broader population. Data collection was also heavily concentrated in the north-west of England, plus the only designated learning disability high secure service, so does not necessarily reflect the views of those in other areas.

Conclusion

The reliance on risk in contemporary secure care policy has, perhaps, been to the detriment of other areas of learning disability nursing, such as informed therapeutic relationship building. Furthermore, it is clear that service designed to care for people with a learning disability and an offending background are changing, and supporting individuals in community settings requires an expanding knowledge base, especially around trauma, and a concomitant approach to care. It seems clear that learning disability nursing has an opportunity as services move relentlessly away from a hospital focus, and that an enhanced understanding of the effect of personal history, together with a renewed therapeutic approach, might help to underpin how we seek to work with complexity.

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