

Initial ideas on the potential value of religion and spirituality in recovery pathways of high secure service users.

The first high secure hospital in England and Wales to admit patients did so 150 years ago. The service aim was to detain patients who could not be detained legally in the prison service by virtue of their lack of *mens rea*. The Mental Health Act 1959; 1983; 1983 as amended in 2007 altered the function of the high secure environment by emphasising the requirement for detention and treatment on the grounds of severe nature and degree of mental disorder and the gravity of the immediate danger to self and others. As such, the needs of a high secure service user can be broadly defined by these concepts of dangerousness and serious mental disorder. By definition, high security infers social exclusion. By the nature of the (modern) service aims of reducing risk and enabling mental health recovery, there is a focus on defining the person by their mental disorder and offending behaviour. If the aims of secure services are to rehabilitate people to function in lesser secure environments and if there is focus only on the aspects of the person related to risk and mental disorder then there is a risk that other aspects of the person are neglected. For example, if we neglect to think about how a person will get their needs met in prosocial ways then they are more vulnerable to making risky decisions in the future. High secure patients present with complex interrelationships between mental disorder and offending behaviour but also difficulties relating to other people, communities and the self. Many patients struggle with feelings of shame, stigma and disempowerment, experiences which can be exacerbated on entering and during high secure care. Many patients struggle to hold a coherent sense of their own identity in relation to other people and the world around them. Again, there is a danger that this can be further distorted by engaging with patients in risk and mental disorder terms and neglecting other parts of the person.

A holistic approach to high secure care was proposed as a model of service delivery and which promoted transparency and ownership of a care pathway (Glorney et al., 2010). Following reviews of service user needs at Broadmoor Hospital, eight domains of need - Therapeutic Engagement, Risk Reduction, Education, Occupational, Mental Health Recovery, Management and Promotion of Physical Healthcare, Diversity and Spirituality, Care Pathway Management - were proposed to enable thought and engagement with different parts of the patient with the aim of integrating these and promoting quality of life across domains. Fundamental to streamlining care and reducing length of stay within high secure services is the promotion of quality of life through the meeting of service user need across a range of domains – such as occupation and activity – that are not restricted to formal medical or psychotherapeutic interventions. Quality of life among high secure service users is not only an important humanitarian factor but also has been associated with the facilitation of motivation for and engagement in interventions that reduce risk and enable mental health recovery. The implication of this is that promoting quality of life and meeting service user need might contribute towards long-term prevention of relapse into mental ill-health and offending behaviour. We know that there are risk factors for offending behaviour such as stress, difficulty in getting needs met and accessing and receiving support. The domains of need model is perhaps symbolic of the tasks of recovery (see Shepherd, Boardman and Slade, 2008), by engaging with the patient to take ownership of their care pathway across domains and to support personal meanings in a recovery journey. In doing so, quality of life is enhanced and this might protect against further offending.

The value of spirituality in recovery is not unknown within the literature on psychosis and within mental health services (e.g. Clarke, 2010a) where engagement with the recovery process is not hindered by the contextual challenges faced within forensic mental health services, such as choice, ownership and hope. The benefits of religion/spirituality for people living through experiences of mental disorder or

incarceration are well-researched. For example, benefits of religion/spirituality include: social support (Bradley, 1995; Ellison & George, 1994); coping strategy (Clear, Hardyman, Stout, Lucken & Dammer, 2000; Pargament, 2001; Park, 2005); increased self-meaning and self-worth (Hefti, 2011; Steger & Frazier, 2005); the reference to a moral script with which to live by (Spalek & El-Hassan, 2007); increased social interaction (Clear et al., 2000). Forming strong, lasting, interpersonal relationships is a fundamental human need and it might be that the social dimension of religion/spirituality is important to forensic mental health populations, particularly with respect to the promotion of social inclusion. There are disadvantages of religion/spirituality too: the potential for the development of negative coping styles, such as reappraisals of God's power and punishment (Bjorck & Thurman, 2007; Phillips & Stein, 2007) and the integration of religious/spiritual beliefs into an altered reality perspective (the reader is referred to Clarke, 2010b, for further commentary and critique of the boundaries between religious beliefs and psychosis). Limited attention has been paid to populations in the UK and even less so to forensic mental health service users, but it seems that there are parallels to be drawn between the benefits of religion/spirituality for some people and the principles of the recovery approach (e.g. Shepherd et al., 2008). In this study, we were interested to explore the personal meaning and importance that religion/spirituality held in the recovery journeys of high secure service users.

Method

Twelve patients at a high secure hospital, with self-identified religious/spiritual needs, were invited to take part in a semi-structured 1:1 interview about the role of religion/spirituality in their recovery journey. Five patients consented to take part and identified their religious/spiritual beliefs as follows: Mr A, Buddhist; Mr B, Agnostic; Mr C, Muslim; Mr D, Agnostic; Mr E, Church of England. Two participants

held the same religious/spiritual beliefs since birth; three participants converted from other religions. Participant ages ranged from 18 to 39 years.

Data were subjected to Interpretative Phenomenological Analysis because of its emphasis on the lived experience of the participant. Four superordinate themes were derived from the data. Brief summaries of each are presented. Illustrative quotes and details of sub-themes are available from the main author, on request.

Brief Overview and Discussion of Data

Religion/Spirituality as an Element of Recovery suggests that religion/spirituality acted as a guiding framework, provided a moral script and a set of standards to live life by. At times of crises or difficulty with coping this framework was drawn upon for guidance and direction. This supports the findings of research that identified that religious coping could be used at times of stress (Pargament, 2001) and that people with a diagnosis of mental disorder might use religion to cope (Kirov, Kemp, Kirov & David, 1998). The guidance provided by the religious/spiritual framework appeared to facilitate self-management, which is a core facet of the recovery approach.

Religion/spirituality seemed to be a fundamental and positive aspect of a participants' *Personal Identity*, which provided significance and meaning. Religion/spirituality was experienced to be an integral part of the self and empowered ownership over mind and behaviour. This holds parallels with a fundamental element of the recovery approach, the importance of holding a personal identity separate from illness or disability. Participants spoke about the relationship between a positive identity and engaging in pro-social behaviour which, for some participants, was linked to personal risk reduction.

Positive interpersonal relations and a sense of social inclusion are fundamental human needs and, for the participants in this study, the religious/spiritual community provided them with a sense of inclusion and belonging, reflected in the

theme *Pro-Social Engagement*. The anthropologist Harvey Whitehouse refers to routine rituals as “the glue that holds social groups together” (Jones, 2013) so promoting a sense of community and social inclusion. It might be that the values of the religious/spiritual community promote pro-social behaviour and a sense of social inclusion beyond the confines of the high secure environment and hold long-term prospects.

Some aspects of the high secure environment seemed to impinge on the potential benefits of religion/spirituality in personal recovery. Difficulties with talking about religion and spirituality with staff, for fear of this important aspect of personal identity being pathologised, seemed to add to the perception that the meeting of religious/spiritual needs were low on the hospital’s agenda, as reflected in the theme *Invalidation*. Support for these findings can be found in the literature (e.g. Clarke, 2010a; Huguelet, Mohr, Borrás, Gillieron & Brandt, 2006) and it might be that for the high secure service users approached to participate in this study, systematic invalidation of religious and spiritual needs had an impact on the low response rate and engagement with 1:1 interviews.

Initial Ideas about Implications for Practice

Religion/spirituality might hold benefits for the recovery journeys of some high secure patients. Religion and spirituality can provide a dynamic framework within which to develop personal resilience. The practice of religion and spirituality might permit healthy expression of agency and control and promote ownership and social inclusion within an environment where it is difficult to locate and achieve these experiences; this might ultimately contribute to risk reduction and mental health restoration. Therefore, it is likely to be important for staff and services to acknowledge the potential value of religious/spiritual beliefs and practice for the patient, even if an initial interpretation might be of one aligned with mental

disorder. It is likely to be important to create a space where it feels safe for patients to speak about religion and spirituality and to facilitate practice within services.

The recovery approach emphasises the role of clinicians as being partners alongside the service user in their recovery journey. Yet findings from this study suggest that this facet of the approach is not being fulfilled for some people for whom religion and spirituality hold personal meaning. It might be that genuine, active communication between staff and patients regarding religious and spiritual needs could hold potential to support recovery and complement formal interventions relating to risk reduction and mental health restoration.

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