THE JOURNAL OF FORENSIC PSYCHIATRY & PSYCHOLOGY, 2015
http://dx.doi.org/10.1080/14789949.2015.1122821

Routledge
Taylor & Francis Group

The implementation of case formulation by probation officers: service user and carer views

Susan Brown[a] and Birgit Völlm[b,c]

[a]School of Health Sciences, University of Nottingham, UK; [b]Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, UK; [c]Nottinghamshire Healthcare NHS Trust, Nottingham, UK

ABSTRACT

Background: The recent UK Government strategy on high-risk offenders with personality disorders (PD) proposes improved identification of this group, assessment of their treatment needs through case formulation (CF) and the subsequent provision of treatment pathways. Little is known about service user and carer views on this strategy. *Aims/Hypotheses*: This study sought to identify the views of personality-disordered (PD) offenders and carers on the proposed role of Probation staff in CF. *Methods*: Three focus groups were carried out, two with service users and one with carers, with a total of 10 participants overall. *Results*: Five themes emerged: 'power', 'conflicting roles', 'trust', 'building a relationship through consistency of care' and 'hope and possibility'. *Conclusions/Practical implications*: Offenders and carers were sceptical regarding the proposed role of Offender Manager (OMs) in CF and this could pose a potential barrier to the successful implementation of the strategy.

ARTICLE HISTORY Received 10 February 2015; Accepted 11 November 2015

KEYWORDS Assessment; personality disorder, probation, case formulation

Introduction

The recent UK Government strategy relating to personality-disordered (PD) offenders – the Offender Personality Disorder (OPD) pathway – heralds a shift in the management of offenders who are deemed as posing a high risk of high harm to others (Department of Health, 2011; Joseph & Benefield, 2010). The OPD pathway involves the early identification of these offenders (including through a PD Screen in the electronic Offender Assessment System, OASys) and the subsequent provision of a case formulation (CF) by the Offender Manager (OM)[1] – in consultation with a psychologist – in order to develop a pathway plan.

CONTACT Birgit Völlm birgit.vollm@nottingham.ac.uk

The pathway plan directs the offender to appropriate interventions (including PD-specific treatment alongside general offending behaviour programmes) either in the community or whilst incarcerated. The strategy involves joint working between the National Offender Management Service (NOMS) and the National Health Service (NHS) allowing OMs to be supported in this new task (i.e. CF) by suitably qualified psychologists.

CF has thus far mainly been used by psychologists and psychiatrists to examine the 'causes, precipitants and maintaining factors' (Young, O'Carroll, & Rayner, 2008) of an individual's (offending) behaviour, and culminates in the production of a psychologically informed formulation of how an individual's treatment should proceed. CF is a core skill for psychiatrists and psychologists (e.g. British Psychological Society Professional Practice Board, 2008; Royal College of Psychiatrists, 2009) though it has until recently received limited attention in forensic settings (e.g. Sturmey, 2010). Little is known about the feasibility or otherwise of the use of CF in professional groups other than those with extensive psychological training. Yet, a core element of the OPD strategy includes providing staff within the Probation Service with training to carry out CF, so that once high risk high harm PD offenders have been identified, their treatment needs can be swiftly assessed, with subsequent direction towards treatment.

The successful implementation of the OPD strategy therefore partly rests upon developing the skills of OMs to conduct CFs, albeit in consultation and under the supervision of psychologists. Whilst OMs' work has always involved the collection of information regarding an offender's background and mental health, they have thus far not been required to synthesise this information into an explanatory formulation to gain a psychologically informed understanding of an offender's problems and to inform their treatment pathway. This shift in remit results in the need to examine a variety of factors: (a) what training should be given to OMs, and whether or not they can be trained to a suitable level, (b) how OMs feel about the prospect of this expansion in their remit and (c) how service users (i.e. offenders with PD, and carers of PD offenders) feel about this expanded role of OMs.

The study described here forms part of a wider programme of research – the IONNA study (Improving Outcomes for high risk offenders with severe personality disorder through an enhanced NHS/National Offender Management Alliance) – that aimed to provide crucial insights into the implementation of the OPD strategy. As part of this programme, we have reported findings from a Delphi survey of professionals (Völlm, 2014) which lent some support for the proposal of Probation staff performing CF. More specifically, about 60% of experts felt that Probation staff could – with the right training – fulfil this task. Experts mostly favoured a cognitive-behavioural model of CF and indicated that the process of CF might be time intensive and required, ideally, an ongoing relationship between the formulator and the offender. In order to examine the feasibility and effectiveness of training in CF, two recent studies have provided

evidence of whether OMs can be taught the requisite skills. A study by Minoudis et al. (2013) found no significant improvement in the OMs' ability to carry out CF following training. A study by the authors (Brown, Patel, Beeley and Völlm, 2015), which involved training of significantly longer duration than that provided by Minoudis et al. (2013), found that OMs can be taught to provide some level of CF, although whether such formulations are at an appropriate standard remained unclear. Thus, the evidence base around OMs' ability to acquire CF skills is mixed. In addition, focus groups with Probation staff revealed significant concerns regarding this new task due to lack of training, resource issues and role clarity (Brown & Völlm, 2013). This paper specifically engages with the last point above, (c) – it focuses on service users' views around OMs being trained in and implementing CF to shed light on potential challenges and benefits for the implementation of the OPD strategy from their particular perspective.

Method

Focus groups

Focus groups were chosen in order to elicit a *discussion* amongst service users around their views towards the implementation of the strategy; the potential for discussion allows people to share views and experiences and be stimulated by each other's ideas (Morgan & Kreuger, 1998). Four different service user groups were targeted:

(a) PD offenders within a prison setting
(b) PD offenders within a high-secure inpatient setting
(c) PD offenders supervised by Probation within the community
(d) carers of PD offenders

A carers' focus group (d) was included to elicit the perspective of carers of PD offenders, who have a unique perspective upon the treatment process that cannot be captured by focusing upon the views of professionals or service users alone.

Focus groups (a), (b) and (d) proceeded as planned; however, group (c) – within a community setting – did not proceed. Whilst the ethical clearance procedure (involving both NOMS and NHS) had approved the use of focus groups within this setting, access was not granted by gatekeepers (senior Probation managers) who felt that a focus group was inappropriate for that setting at that particular time; this was due to a recent incident within the setting that caused distress to clients and created a heightened sense of tension. In addition, there were fears around confidentiality and concerns that participants might disclose material that could be used against them by other participants once the focus group had ended (this concern was not raised in the other settings). Individual interviews were suggested as an alternative; however, it was not possible to incorporate a change in the study design within the allotted time frame.

Recruitment and selection

Recruitment of service users

Recruitment took place in two different ways, responding to the different regimes in which participants lived:

Prison setting. Potential participants were identified by a member of their health care team (a consultant forensic psychiatrist) according to the presence of a PD diagnosis. Potential participants were then provided with recruitment material, and given the opportunity to volunteer for participation. Those who expressed an interest to the health care team were then vetted in order to confirm safety for a focus group involving female researchers. Two participants completed the recruitment process and attended the group (see below for a discussion of group size); prison staff were not present in the room during the focus group.

High-secure setting. Two treatment wards were selected for recruitment based upon their remit of working specifically with offenders with PD diagnoses. Researchers were invited to attend a ward meeting involving patients to briefly outline the research and hand out recruitment materials. Patients were then given the opportunity to volunteer. Safety clearance procedures (in relation to non-mixing of patients) were then carried out. Three participants completed the recruitment process and attended the focus group; hospital staff were not present in the room during the focus group.

Recruitment of carers

Recruitment of carers took place in two ways. Firstly, staff at two inpatient psychiatric facilities (one medium secure and one high secure) sent out recruitment materials to carers on behalf of the research team; recipients were invited to respond directly to the research team. Secondly, a member of the research team attended carers' events at these two setting in order to briefly present on the research and hand out recruitment materials. The criterion for carer participants was that they must be a carer to someone with PD, suspected PD or PD traits; however, it transpired in the focus groups that the relatives of the carers all had an actual diagnosis of PD. By virtue of the setting in which they were recruited, an offending history was automatically deemed to be present in their relative / close friend. Five volunteers attended.

Sample characteristics Service users

Specific characteristics (such as age, offending history, diagnosis) were not collected from participants and no diagnostic assessments were undertaken in

order to not jeopardise (or bias) recruitment of this difficult to recruit population of PD patients which often present with difficulties trusting professionals with their personal information. Exact diagnostic specification and detailed background information was not deemed relevant for the purpose of this research and would not have had any impact upon inclusion or otherwise.

However, the following characteristics were known or could be inferred:

- All participants were adult males
- All participants had a diagnosis of PD (see recruitment above)
- By virtue of their residing within a Category B prison or high-secure hospital, participants were deemed to have a history of serious (as opposed to minor) offending.[2]

Carers

All carers were adults; three females and two males.

Carers self-identified as being carers of someone with a PD diagnosis with a history of offending. Relationships to the offender included parent, close friend and partner, and involved caring responsibilities before and during their contact with the criminal justice system.

Focus group schedules

Schedules were created for the two types of focus group (service user and carer; available from the authors on request). Schedules were not rigidly followed, but were used as prompts or guides to ensure that each area had been addressed. Focus groups lasted between 60 and 90 min.

Each focus group began with a description of CF to ensure a shared understanding of what was being discussed. The process of CF was described to participants as a process where a professional gathers information and where 'All this information is brought together to understand what your difficulties are and how they have arisen. This includes your background experiences, what triggers your difficulties, what maintains them and what makes them better'.

Service user focus groups then included the following: previous experience of CF (i.e. do participants recognise having received it); if so, whether the process was helpful; how CF should be carried out, i.e. by whom, should anyone else (e.g. carers) be involved in the process, what information might be useful for understanding offending behaviour, and what participants think about Probation staff carrying out CF.

A slightly different schedule was used for carers recognising that they would not have personal experience of the CF process but would have a unique perspective on aspects of offenders' receipt of care. The carer focus group included the following: participants' background as a carer (i.e. a brief outline of their connection to the person they care for), length of time before a psychiatric (PD)

diagnosis was given, whether participants were involved in the process of diagnosis, whether participants recognise the process of CF as having taken place, what information might be useful in understanding offending behaviour and how participants feel about Probation staff being involved in the process of CF.

Focus groups were facilitated by a senior clinical academic and consultant forensic psychiatrist with extensive experience in working with PD offenders (BV) and a medical sociologist (SB). They were co-facilitated by a member of the PPI (patient and public involvement) reference group. [3]

Analysis

Focus groups were recorded, transcribed verbatim and checked for accuracy by one of the researchers. A thematic analysis (Braun & Clarke, 2006) was carried out, using the following inductive process. Transcripts were coded using two approaches: firstly, open coding (Strauss & Corbin, 1998) was carried out (i.e. identifying content of interest to the researchers, irrespective of its relation to questioning); secondly, responses to pre-defined question areas were coded and compared. All codes were examined together, grouped where relevant and similar codes merged, then examined for overarching themes, allowing a coding frame to be developed at a more abstracted level (Green & Thorogood, 2009). Coding was carried out by SB. Both authors discussed the initial coding, and subsequently the emergent coding frame; there were no disagreements.

Results

During analysis, five clear themes emerged. The first three of these are overlapping and reflect different aspects of an overarching concern over OMs carrying out CF; these are 'power', 'trust' and 'conflicting roles'. The final two are distinct from this concern: 'building a relationship through consistency of care' and 'hope and possibility'. These themes are now discussed in turn. It should be noted that not all themes discussed below occurred in the carer focus group, which encompassed an inherently different perspective; carer views did not cover the themes around power and concern over role conflict, which are more likely to reflect the immediate concerns of service users.

Concern over OMs carrying out CF

The three interlinked themes described above were the most prominent ones emerging from the data. They are addressed in turn. Separating them into different constituent parts allows a more focused discussion of their nuances and greater clarity of discussion, but it is acknowledged that they are closely linked, with much overlap.

Role conflict: perceived conflict between the OMs' traditional and new roles

Participants described perceiving OMs' main role as relating to matters of *custody*, including monitoring of behaviour, suitability for parole and/or recall to prison. They viewed OMs as being there to ensure that rules are adhered to, whether in the community or in custody and to administer punishment if deemed necessary. In contrast, when discussing the process of CF, it was perceived within a paradigm of care, relating to addressing their mental well-being, and the difficult process of beginning to share their potentially deeply troubled personal histories and entering some form of therapy. When the process of CF was being considered, it was described as a process that requires trust and safety, in terms of feeling able to disclose their history, and current mental well-being. OMs were not perceived as suitable partners with whom to share such personal information, because of these two very contrasting types of role. The expansion of OMs' work into this new territory introduced – in the eyes of participants – potential conflict into their status. The old role clashes with the new: control versus care; surveillance versus sharing of deeply personal information. Examples from the groups are as follows:

> Focus group 1
>
> P1: They'd have to change people's relationship with probation officers straight away. The way I see probation is: they're there to watch me and make sure I don't do anything wrong; otherwise they'll lock me up
>
> Focus group 1
>
> P3: I've been under probation, they breached us [me] every time; so I've got negatives with them 'cause they breach us…[…]
>
> P1: So, what I want to know is why do they want to get involved with mental health… it just doesn't seem right to me, probation and mental health, it just doesn't work with each other, you know what I mean.
>
> P2: Yeah, I'd find it really hard to trust a probation officer with what I'd say to psychologists…

Whilst there was variation expressed in relation to how OMs are perceived (for example, some were described as 'keen to breach', whilst others were described as less so), their role was seen primarily as that of enforcing and monitoring issues of custody, and participants perceived this as at odds with the type of relationship that is required when addressing their mental health. Participants speculated that this could particularly be the case if there is an existing and contentious relationship between OM and offender (for example, if there is history of the OM recalling the offender to prison).

Participants did already have experience of meeting with an OM and discussing certain personal information, but this was usually at the pre-sentence stage, and for a different purpose; even though much of this information could

be used within a formulation, its current purpose is not perceived by participants as relating to any therapeutic outcome. When talking with OMs, OMs were described as being interested in the 'here and now' of why an offence had taken place, and not so much in the offender's past.

Power

Participants were wary of the increased power that OMs could potentially hold over their lives if their mental health care (or assessment relating to it) were further placed in the hands of OMs. Essentially, participants expressed that the expansion of OMs' role would leave them with 'too much' power over the offenders. Participants discussed being wary of the power held by psychiatrists and psychologists, whose recommendations could significantly affect their lives, for example by shaping the outcome of a parole hearing or the duration of their treatment. Whilst this is different to the proposed role of OMs carrying out CF, nonetheless the suggestion that OMs might begin to get involved in this kind of assessment and potentially playing a greater role in shaping future therapeutic interventions was viewed as a worrying shift. During the recruitment phase, when told about the topic of the study, one participant voiced concerns that this increased power could be subject to abuse; however, this was not voiced during the focus group, which occurred at a later date.

Participants also voiced concerns about the quality of the assessments that OMs could provide, when compared to that done by psychologists. There was an assumption that any training would necessarily be a short course and in no way comparable to the training undergone by a psychologist. For this reason, the quality of potential assessments was viewed as incomparable to one carried out by a mental health professional. Given that an OM's assessment may still have a significant impact upon the offender's life, this was seen as concerning; extra power was being placed in the hands of people who may not actually be adequately trained to use it. Examples from the focus groups are given below:

> Focus group 1
>
> P1: For me putting trust in psychology and psychiatry is a big massive issue… because psychology and psychiatry hold so much power… a flick of a pen could cost you a ten year in a hospital or prison, and to put trust into someone who has that much power over you, you have to make sure you're ready and you understand what's coming up ahead…
>
> Focus group 2
>
> P2: … to get probation to understand mental health I don't think it will ever happen.
>
> P1: … you can't send probation on a course for six week and they come back and diagnose us 'oh yeah you're fit and well', no, I don't think so.
>
> I. You don't think it's a good idea?

> P1. Do you know what I'm saying, well they can sit there and listen to us but they can't sit there and just start saying, 'right well', you start giving them power, 'right, yeah, there you go, Sue, whatever your name is, yeah, you've got mental health issues, this and that, this and that', yeah, write some crap down on a piece of paper, bump … gone … mental health hospitals'll end up being full, they will.

Participants were therefore wary of the widening remit of OMs' role in CF and a potentially more prominent role in defining treatment pathways. There is overlap between this theme and the role conflict already discussed above; the seemingly conflicting roles of care and control, being held by someone who has not received the same level of training as a psychologist or psychiatrist (and with whom there *may* be an existing and contentious relationship), is met with concern.

Trust: the importance of relationship building and trust

Participants discussed the difficulties they experienced when opening up to professionals about their mental health, emotional life and traumatic experiences from their past; the majority of participants specifically stated that they have issues with trust and paranoia that affect this process. Previous experiences of opening up to professionals predominantly involved interaction with mental health professionals (psychiatrists, psychologists and mental health nurses). Participants discussed the importance of trust and of the existence of some sort of relationship, in feeling able to open up to professionals about sensitive issues; building a relationship over a period of time – and with the same professional – was perceived as crucial to being able to discuss their experiences openly and honestly. Participants described a gradual process of opening up that involved remaining guarded about their inner experiences and personal history until a trusting relationship had formed, something that could only unfold over time (and with consistency of staff, which links into the theme 'consistency' below). An example from the data is as follows:

> Focus group 2
>
> P1. I don't like opening my business up to Tom, Dick and Harry […] I want to sit there and I want to get to know them 'til they know me […] It's like you, would you just reel off everything about your life to me, you've just met me […]
>
> P2. I'm the same, I'll only open up to someone I feel trustworthy with

This sentiment was also echoed in the carers' group, and CF was viewed as something that needed to be carried out over time to be effective. As already addressed above, participants expressed doubt as to whether it would be possible to discuss such issues with an OM whose role is perceived so differently to that of the mental health professionals with whom they *still* experienced issues of trust and relationship building that took time to overcome; OMs' roles may involve surveillance and disciplinary action against the offender, compounding issues of trust, as discussed. If indeed it were possible to envision sharing this

information with their OM, participants were concerned that this would not be possible (or rather, *effective*) unless the process took place over time, and with regular contact with the OM. They expressed serious reservations about the possibility of this being done as part of a one-off assessment, for these reasons.[4]

Consistency of care: minimising the number of staff involved in their care

A lack of consistency – in relation to the involvement of various different professionals relating to their mental health care – was identified as problematic by participants. As mentioned above, participants expressed dislike at being asked about their emotional life or background by a professional they hadn't met before, for reasons of trust. In addition, being asked the same questions over time by a series of different professionals left participants frustrated and less willing to respond openly. This is partly because of a perceived lack of consistency in care and frustration towards the system of care that is in place. Participants discussed the involvement of new or additional professionals relating to their mental health care as being potentially negative; participants may already feel overexposed in terms of who is involved in their care and therefore who has access to information regarding their background, including trauma (participants also cited examples of breaches of trust amongst staff in relation to such information). The inclusion of OMs (in relation to their mental well-being) is – of course – an expansion in the number of people involved in discussing their mental health issues. The following excerpt is from a discussion relating to multidisciplinary teams and so relates to only a section of the above (the involvement of multiple professionals). However, the example usefully shows this 'over-exposure':

> Focus group 1
>
> P2. You don't realise why people are in the room, you go into a ward round and they say 'Do you know everybody?', and you say 'No, I don't know that lady there' and they say 'Oh, that's the pharmacist", why does she have to hear how my behaviour's been, you know what I mean? You can't work it out [...] You become overwhelmed and they say 'How do you feel?', everyone's there staring at you and like you say you have the pharmacist looking at you, you have OT looking at you and you're thinking 'Well I don't really need to tell you's how I'm feeling', you know, how I'm feeling, the staff will hand over to you but yet again you're having to explain yourself in front of strangers and it makes you feel uncomfortable but it's like 'he's not like he was in OT, he's outgoing, he's...' and you're sitting there crapping yourself and going [thinking] I don't really want to say nothing … because you feel intimidated, you feel pressured, I think if they reduced the amount of people who were there it would be easier.

The above illustrates concern at the number of people involved in the participant's care (and uses an example of the number of people in the room at any one time), but also shows concern at the presence of people who may not have core involvement in their therapeutic process (when it is being discussed). Whilst

the above extract refers to a ward round (and thus care within a therapeutic setting, which is different to OPD implementation), the underlying issue being discussed is one of consistency in staff and minimisation of involvement of new people pertaining to mental health care (as also indicated in the quotation in the previous section). Minimising the number of people involved in therapeutic interactions and the discussion of sensitive information more generally – from the point of view of participants – is preferred. This partly overlaps with the theme of trust and relationship building, but is also distinct in that it reflects upon the *process* of care provision, and how changes in staff, including the involvement of extra staff, may be unwelcome.

A seeming lack of consistency of care was also expressed as a point of frustration in the carers' focus group. Carers discussed frequent changes of psychiatrists and concerns that this was to the detriment of the care received by their family members; a lack of consistency was a barrier to the building up of a working relationship (with the patient, but also with their family) and any advantages – most notably, greater insight into their loved one's care needs – that might arise as a result.

Hope: the possibility of earlier identification

Whilst the majority of discussion around training OMs to carry out CF related to concerns and potential barriers, a significant positive was outlined by all focus groups. There was positivity expressed about training OMs to know more about mental health (including PD) in general; this was not because their involvement in CF would be useful per se, but because they would become better at identifying PD and mental health problems in their wider caseloads, which could lead to earlier identification. Frequent mention was made that service users' 'problems' (i.e. that PD was underlying their offending behaviour) were not picked up until they had committed a serious crime and they were therefore under much greater scrutiny including by mental health professionals; help was only given to participants when the seriousness of their 'problems' could not be ignored. This was echoed by the carer group, where participants expressed difficulty in obtaining help for their loved ones, and frustration at not being 'believed' by General Practitioners and criminal justice staff when trying to explain that their loved ones had a 'problem'. Thus in all groups, frustration was expressed that it was only through committing a serious crime that help was ultimately received. An example from the carers' focus group is as follows:

> Focus group 3
>
> P1: So five, six years where we.. well more than that.. where we first suspected she'd got a problem, couldn't get anybody else to [suspect a problem], it's taken all that time and it took that offense to get the help [...] But in a bizarre way if she hadn't done that we wouldn't be where we are now, she wouldn't be in [Name of treatment setting], getting the treatment she's getting, so that's how we sort

> of look upon it.. that it was an ill wind sort of thing. [...] Whereas if somebody had listened to me in 2005 probably, when she was [anonymised – minor offences] all the time, then maybe the problem could have been avoided.

The positive of receiving appropriate diagnosis and help is outweighed by the consequences of the crime that they have committed, and there is frustration and regret that intervention could not have been at an earlier point. Although some participants stated that their PD diagnoses had been known about since youth, appropriate help was not given until more serious crimes had been committed. There was a perception that if OMs were trained to understand more about and identify PD and mental health difficulties, then this would be a potential source of earlier identification for those whose crimes relate to such underlying problems, although this is useful only if appropriate help can then be provided. The following excerpt illustrates this:

> Focus group 1
>
> P3. If they could do a good job and do things right I'd be all for it.. it'd save people coming here.

This particular outcome (and not the involvement of OMs in CF per se) was welcomed.

Discussion

Here we presented finding of three focus groups of service user offenders with PD and their carers on the new OPD strategy for high risk high harm offenders. Considerable concerns were expressed by participants of both kinds of groups regarding the proposed expansion of the role of Probation to include CF. As outlined in the Limitations section below, at the time of this research the OPD strategy was in its infancy and therefore concerns might have been inflated by the uncertainty surrounding some aspects of its implementation. Nevertheless, we believe the concerns expressed here are of relevance in the ongoing roll out of the strategy implementation.

The themes identified provide insight into potential barriers to the successful implementation of CF by OMs; these barriers are twofold. Firstly, the themes highlight potential problems in how offenders might perceive OMs carrying out CF. That is to say concerns around a perceived role conflict in OMs' new tasks may lead to a lack of trust on the part of offenders and an unwillingness to discuss issues around mental well-being and personal history. Whilst such role conflict within the work of OMs – relating to rehabilitation and public protection – has been noted for some time, this is exacerbated by a shift towards greater involvement in 'history taking' in areas outside the traditional criminogenic needs domain. We have reported elsewhere (Brown & Völlm, 2013) that, in their data collection pre-OPD strategy implementation, OMs have described a tendency not to delve deeply into personal areas relating to offenders' history

and mental health when completing OASys assessments. Whilst they did seek such information, OMs expressed concerns about entering areas that might lead to material being disclosed they might feel ill-equipped to deal with. While the new strategy is a change in *emphasis* rather than the design of a completely new role for OMs, this re-emphasising is pertinent in the view of OMs and was also of great concern to the participants in this study.

Interestingly, offenders' perception of OMs role is echoed in both official role descriptions and OMs' own perceptions. In the UK, unlike in other European countries, the main role of Probation is to protect the public from offenders supervised by them, rather than necessarily to promote their well-being as a primary goal (House of Commons Justice Committee, 2011). When Probation staff were asked to reflect on the new PD strategy (as reported in Brown & Völlm, 2013), they too were concerned about mixing their public protection role with one of being a confidant for those on their caseload. This area of concern therefore echoes a core role conflict and thus needs serious consideration in the implementation of the OPD strategy.

Secondly, even if this first barrier can be overcome, the requirement for a CF to be carried out on either a one-off basis, or over a relatively short period of time, potentially prevents the formation of a trusting relationship that might enable disclosure of information that is relevant and necessary for a successful CF. Offenders may prefer to remain guarded and not disclose information that they feel vulnerable disclosing, until they know the OM well enough. We previously found that OMs expressed the same concerns, i.e. that offenders did not disclose sensitive personal information until some form of working relationship has been developed (Brown & Völlm, 2013), issues that the authors have previously argued may hinder the effective implementation of CF based upon such information.

When discussing CF, it is possible that the process of CF and the wider therapeutic process of discussing a person's history and background may have been conflated by focus group members; conversely, there is inevitably some overlap between the two and CFs may evolve over time as more is known about a person. Thus, issues of opening up and discussing traumatic events (and indeed the need for this to be done over time) will be relevant to the process of CF as well as the development of an ongoing therapeutic relationship.

One will also have to bear in mind that the above themes were drawn out of discussion amongst offenders, many of whom have issues of trust and paranoia. Whilst it is to some extent to be expected that issues of trust are discussed, it is nevertheless important to acknowledge that this insight is useful, because the OPD strategy is aimed at precisely this population. Thus, characteristics of this group – and how they affect research findings – are also relevant to enactment of the strategy itself. In addition to these issues of trust and paranoia, PD offenders present with a range of traits that can affect the development of a constructive working relationship, e.g. antiauthoritarian attitude, repeated

antisocial behaviour, challenging boundaries, deceitfulness, hostility, etc. It is crucial that OMs are aware of this potential impact and are trained in how to counteract the negative effects of these PD characteristics; training materials have been developed to assist this process, e.g. Craissati et al. (2015). Clarity of role and boundaries and the development of a trusting relationship seem crucial in working with PD offenders effectively.

Providing OMs with greater understanding about PD and mental health was received well, but not because of their ability to carry out CF. Rather, the possibility that serious mental health problems and PD might be more quickly detected by OMs who are in contact with offenders was seen as holding great potential in directing individuals towards care at a more appropriate point – most notably, before their crimes escalate to the point of requiring forced intervention by mental health professionals. Research has also shown that knowledge of PD may lead to a more empathetic attitude towards this group, at least in nursing staff (e.g. Bowers, McFarlane, Kiyimba, Clark, & Alexander, 2000), though this finding was not replicated in Probation staff (Brown, Patel, Beeley, & Völlm, 2015). Furthermore, the possible benefits of identifying offenders' PD and mental health problems before very serious offences are committed may not be realised if training is given to OMs who only work with high-harm offenders. Thus, whilst improving OMs' ability to identify PD is an aim of the OPD strategy, its benefits are potentially limited by focusing the process on high harm offenders only. Thus, the potential benefits of early identification may be foregone if OMs who work with medium- and low-harm offenders do not receive additional training that may help identify such problems *before* they become 'high harm'.

Limitations

The main limitation of this research relates to the small size of two of our focus groups. Focus group size can vary significantly, however, a typical recommended size for qualitative research is between four and eight people (Barbour, 2007). Two of the groups, those consisting of service users, were below this number (three and two participants, respectively) and so the applicability of the label 'focus group' requires consideration. When carrying out focus groups with hard-to-reach participants, or from naturally occurring groups that are very small, recruitment of smaller numbers is to be expected. McClelland and Newell (2008) describe similar constraints and use the label 'focus group' with just two people, as it is the opportunity for (and realisation of) interaction that is key. Morgan, Ataie, Carder, and Hoffman (2013) point out the paucity of research around the use of two-person (un-acquainted) interviews as a viable alternative to focus groups or individual interviews. Morgan, (2013) research uses 'dyadic interviews' (with individuals who are pre-acquainted, such as couples or friends) and highlight the opportunity for interaction; they position this as similar to focus groups, but suggest there are pertinent differences, as the type of discussion that takes

place may be different to the dynamic of a larger group. Rather than invalidating the content of discussion though – which remains a constructed event where the interaction of people around a particular topic of discussion unfolds – it should be acknowledged that a dual interview can have similar properties to focus groups. Others have pointed out the potential of smaller groups to facilitate depth of discussion, particularly where individuals might find it difficult to express themselves due to low self-esteem or confidence (Rabiee, 2004). This study provides an example where a two- and three-person group[5] is viewed as appropriate for the topic under investigation, and the authors highlight this is an area meriting further research. However, the authors acknowledge that the small sample size for this study points towards the need for caution in generalising the findings; the findings should be viewed as pointing towards significant themes that merit exploration through further research.

It is also important to consider the applicability of the findings in relation to the high risk high harm offenders at whom the strategy is aimed. The study involved offenders who resided in settings detaining more serious offenders – a high secure hospital and a Cat B prison – and they all had a diagnosis of PD. At the time of this study the implementation of the OPD strategy was still in its infancy and the exact operationalisation of constructs and the procedures around CF (now generally accepted to be through a process of consultation, see e.g. Minoudis, Shaw, & Craissati, 2012) were under development. However, we would therefore argue that the background of our participants was sufficiently close to those who are now in receipt of the CF process, given their diagnosis, location and experience with Probation. The service user participants were recruited in all-male settings, however, thus it cannot be known whether the findings are applicable to female offenders. At any rate, it would be informative to investigate the experiences of service users who have been in receipt of the new services and whether the issues identified in our study persist.

Notes

1. The role of Offender Manager was introduced with the inception of the National Offender Management Service (NOMS) in the UK in 2004 which combined the responsibilities for Her Majesty's Prison Service and the National Probation Service. The role is similar to that of 'ProbationOfficer' but is now being preferred to emphasise the broad responsibilities of the role, including provision of reports for courts to guide decisions about sentencing, support of offenders throughout their prison sentence and following release as well as the supervision of offenders serving community sentences.
2. Security levels in English prisons are divided into four levels with Category A being the most secure and Category D providing open conditions. High secure hospitals accommodate individuals that present a 'grave and immediate danger'. While high secure hospitals can also admit patients without an offending history, this is the case in under 10% of individuals and almost exclusively applies to female and learning disabled populations. The content of the focus groups

also revealed that participants recruited from this setting did indeed all have offending histories.

3. The IONNA study created a PPI reference group comprised of individuals with either lived experience of PD and offending or being carers of such individuals. The reference group informed the conduct of the study including its remit and practical implementation (such as development of focus group schedules). A member of this group was present at all focus groups.
4. Whilst there remained some uncertainty about how CF was to be implemented by OMs under this strategy, it was likely that it was intended to be an assessment only (that then directs the offender towards appropriate treatment) and not a process that takes place over time – though the assessment would take place as part of a longer, ongoing relationship with the OM.
5. Participants in the two-person group were acquainted with each other. In the three-person group, two of the participants were acquainted.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This article presents independent research funded by the National Institute for Health Research (NIHR) under its Programme Development Grants Programme [Grant Reference Number RP-DG-0611-10012]. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

References

Barbour, R. (2007). *Doing focus groups*. London: Sage.

Bowers, L., McFarlane, L., Kiyimba, F., Clark, N., & Alexander, J. (2000). *Factors underlying and maintaining nurses' attitudes to patients with severe personality disorder.* Final Report to National Forensic Mental Health R & D. London: City University.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

British Psychological Society Professional Practice Board. (2008). *Generic professional practice guidelines* (2nd ed.). Leicester: British Psychological Society.

Brown, S., Patel, G., Beeley, C., & Völlm, B. (2015). *Training probation officers in case formulation for personality disordered offenders*. Manuscript submitted for publication.

Brown, S., & Völlm, B. (2013). Case formulation in personality disordered offenders: Views from the front line. *Criminal Behaviour and Mental Health,* 23, 263–273.

Craissati, J., Minoudis, P., Shaw, J., Chuan, S. J., Simons, S., & Joseph, N. (2015). *Working with personality disordered offenders: A practitioners guide*. Ministry of Justice Publications. Retrieved from www.justice.gov.uk

Department of Health. (2011). *Consultation on the offender personality disorder pathway implementation Plan* [online]. Department of Health Publications. Retrieved from http://www.rcpsych.ac.uk/pdf/carepathway.pdf

Green, J., & Thorogood, N. (2009). *Qualitative methods for health research* (2nd ed.). London: Sage.

House of Commons Justice Committee. (2011). *The role of the probation service*. London: The Stationery Office.

Joseph, N., & Benefield, N. (2010). The development of an offender personality disorder strategy. *Mental Health Review, 5*, 10–15.

McClelland, G., & Newell, R. (2008). A qualitative study of the experiences of mothers involved in street-based prostitution and problematic substance use. *Journal of Research in Nursing, 13*, 437–447.

Minoudis, P., Craissati, J., Shaw, J., McMurran, M., Freestone, M., Chuan, S., & Leonard, A. (2013). An evaluation of case formulation training and consultation with probation officers. *Criminal Behaviour and Mental Health, 23*, 252–262.

Minoudis, P., Shaw, J., & Craissati, J. (2012). The London pathways project: Evaluating the effectiveness of a consultation model for personality disordered offenders. *Criminal Behaviour and Mental Health, 22*, 218–232.

Morgan, D., Ataie, J., Carder, P., & Hoffman, K. (2013) Introducing dyadic interviews as a method for collecting qualitative data. *Qualitative Health Research*, 23(9), 1276–1284.

Morgan, D., & Kreuger, R. (1998). *The focus group kit*. Thousand Oaks, CA: Sage.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society, 63*, 655–660.

Royal College of Psychiatrists. (2009). *A competency based curriculum for specialist training in psychiatry*. London: Royal College of Psychiatrists.

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Sturmey, P. (2010). Case formulation in forensic psychology. In M. Daffern, L. Jones, & J. Shine (Eds.), *Offence paralleling behaviour* (pp. 25–52). Chichester: John Wiley & Sons.

Völlm, B. (2014). Case formulation in personality disordered offenders – a Delphi Survey of professionals. *Criminal behaviour and mental health, 24*, 60–80.

Young, N., O'Carroll, M. & Rayner, L. (2008). Making a difference. In T. Stickley & T. Bassett (Eds.), *Learning about mental health practice* (pp. 173–193). Chichester: John Wiley & Sons.