Clinical Psychologists' perceptions of barriers and facilitators to engaging service users in Index Offence Assessment and Formulation within a medium secure unit

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Abstract

Index Offence Assessment and Formulation (IOAF) helps service users (SU) in secure units to make sense of their Index Offence, provides detailed understanding of risk and contributes to treatment planning and discharge decisions. Clinical Psychologists' perceptions of barriers and facilitators to engaging SUs in IOAF within the Men's and Women's services of one medium secure unit were explored through focus groups. Thematic analysis identified two relevant domains: person-specific factors and the organisational context. Person-specific barriers included challenges in working with fragmented narratives, conflicting motivations to engage, service-user defences, and distorted perceptions of Clinical Psychologists' roles. Giving clarity and choice to SUs facilitated engagement with the work. Regarding the organisational context, Clinical Psychologists within both services identified the importance of having adequate resources and care-team support to complete this work. Findings highlight the importance of developing an evidence-based framework for IOAF to be embedded within clear 'risk' care pathways through secure services.

Introduction

Forensic mental health services offer treatment to approximately 4000 offenders in secure settings across England and Wales (Ministry of Justice, 2010), focusing on mental health needs and the risk of re-offending (Kennedy, 2002). When making treatment and discharge decisions for individuals within this population neither diagnosis nor offence classification provide sufficient insight into the specific factors resulting in the individual's pathway to offending and potentially influencing future risk (Hart, Sturmey, Logan, & McMurran, 2011). Psychologists in forensic settings, either clinically and/or forensically trained, are ideally placed to bridge this gap with their core skills in undertaking assessments of complex behaviours and using psychological models to interpret this information to produce individualised formulations.

Understanding the factors leading to past offending (including the most recent or Index Offence) provides information about circumstances which may influence current and future risk (Hart et al., 2011). Index Offence Assessment and Formulation (IOAF) is typically a core duty of psychologists working within forensic mental health services, as part of comprehensive forensic case formulation (Gudjonsson & Young, 2007) and helps inform a wide range of decisions including level of security required, treatment needs, and access to leave.

Psychological formulation refers to both a process where an understanding of an individual's difficulties is developed using psychological theory, and the product of that process (Johnstone, Whomsley, Cole, & Oliver, 2011). Best practice guidelines developed outside of forensic services highlight the importance of formulating collaboratively with the individual in question (Johnstone et al., 2011). Such collaboration potentially creates more challenges when applied to the Index Offence where practitioners may experience conflict between therapeutic and forensic roles (Greenberg & Shuman, 1997) and where the behaviour in question is not directly available for observation (Hart et al., 2011); whilst hypotheses about the offence can be generated through assessment and formulation, these can only be tested via proxies such as offence paralleling behaviours (Jones, 2010). Moves to translate recovery-based models to forensic mental health services emphasise the importance of involving service users in developing a collaborative understanding of their offending as part of their rehabilitation (Drennan & Alred, 2012), however little research has been carried out into how this is achieved.

(West & Greenall, 2011) critique the over-reliance on offender accounts when analysing the Index Offence, emphasising the importance of structured review of multiple sources of

information, such as crime scene data and witness statements. Their model of Index Offence Analysis describes input from the service user/offender as providing a 'baseline' account after which collateral information is reviewed by professionals, with the product being as unbiased an understanding of the offence as is possible, produced on behalf of supervising organisations (West & Greenall, 2011).

It is well acknowledged that an individual's narrative of the offence and surrounding events is likely to be affected by rationalisations, social desirable responding, denial and memory problems (Maruna & Mann, 2006; Taylor & Kopelman, 1984; Yates, 2009). Nevertheless, identifying discrepancies between subjective and objective accounts and discussing these with the individual through the process of collaborative formulation is likely to provide greater understanding about the individual's readiness and motivation to engage openly with rehabilitation attempts, it is also an important purpose of forensic mental health services. Moreover, engaging in the process of IOAF may form the first step to participating in psychological and other rehabilitative work to reduce future risk and is in line with recovery principles. Clearly a central challenge of collaborative IOAF is to avoid accepting or even creating further rationalisations for offending behaviour whilst developing a shared understanding (Herman, 1990).

Information gained from IOAF may contribute to and compliment structured risk assessment using validated tools, such as the Historical, Clinical, Risk Management-20, Version 3 (Douglas, Hart, Webster, & Belfrage, 2013). The validity of the HCR-20 V3 and similar tools depends on the quality and completeness of the information drawn upon in the process of making individual risk assessments (Webster, Douglas, Eaves, & Hart, 1997). Offender engagement with IOAF potentially contributes a unique source of information to HCR-20 completion that may be particularly relevant to rating the relevance of risk factors for the individual, identifying idiographic risk factors, and contributing to risk scenario construction.

Difficulties engaging offenders in psychological work are common: barriers include fear of failure and difficulties maintaining relationships (Clarke, Fardouly, & McMurran, 2013). Similar barriers may impact upon engagement in IOAF – disclosing details of the Index Offence may elicit shame and fears about consequences of disclosure, such as delaying discharge. Not engaging in IOAF is problematic as poorly understood risks can delay discharge to lower security, potentially leading to extensive periods of hospitalisation, institutionalisation and

difficulties with rehabilitation (Doyle et al., 2014). The mean length of stay in costly medium secure units (MSU) is increasing (Rutherford & Duggan, 2008), which may be reflective of an increased awareness of the long-term risks posed by offenders in secure units conflicting with difficulties engaging offenders in IOAF so as to understand and reduce those risks.

The shortage of research on IOAF is surprising given that forensic case formulation forms a core part of the role of clinical and/or forensic psychologists within forensic mental health settings (Gudjonsson & Young, 2007). Whilst the literature on psychological formulation in general is becoming well-established (e.g. Johnstone & Dallos, 2013), much less is understood about how this is translated to forensic settings, what challenges are faced and how these are managed. We sought to examine Clinical Psychologists' perceptions of the common barriers and facilitators to engaging service users in IOAF within two services within one MSU in order to develop our understanding of IOAF within secure settings.

Method

Design

This qualitative study used focus groups to examine Clinical Psychologists' perceptions of barriers and facilitators to IOAF within two secure settings: the Men's and Women's service contained within one MSU. During the research period the Men's service had a ratio of one Clinical Psychologist to every 15 SUs and the Women's service had a ratio of one Clinical Psychologist to every 4 SUs. Psychologists were either dual-trained Clinical Forensic Psychologists or Clinical Psychologists who had specialised in forensic mental health. Referral criteria for the MSU included SUs with mental health difficulties who had committed a criminal offence, typically an offence against a person, or SUs who present with risks beyond the scope of standard psychiatric hospitals.

Materials

A semi-structured interview schedule was developed consisting of seven questions including: 1) what is your understanding of the definition of IOAF; 2) do you agree there are difficulties implementing IOAF within the MSU; 3) what are the most frequent barriers that prevent SUs from engaging in IOAF; 4) what do you think motivates SUs to engage in IOAF; and 5) what would the ideal service look like that allowed IOAF to happen to the best of its potential; 6) are

there any organisational, training or resource-related needs that might help facilitate SUs' engagement in IOAF; and 7) what are the implications for SUs who do not engage in IOAF in terms of treatment or risk management?

Participants

Five of six Clinical Psychologists participated in the Men's service focus group. Three of three Clinical Psychologists participated in the Women's service focus group. Written informed consent was gained prior to participation, with the focus group questions given to participants in advance. Focus groups were conducted within the MSU, facilitated by the researcher using the semi-structured interview schedule, audio-recorded and lasted 60-90 minutes.

Analysis

Thematic analysis was completed separately for the Men's and Women's services according to the Braun and Clarke (2006) guidelines. The two focus group interviews were transcribed verbatim from the audio-recordings. Initial immersion in the data involved repeated readings of each transcript, noting preliminary thoughts and patterns. Using the computer program 'NVivo' version 10.1.2, coding identified meaningful segments of data with equal attention given to all data items. Codes were organised into thematic maps containing themes and sub-themes. Themes were reviewed against individual data extracts and the entire dataset and exhaustively collapsed, divided and discarded until the essence of the data was captured. An independent researcher read the transcripts and discussed the representativeness of themes with the first coder until consensus was reached. Finally, detailed analysis of each theme was written with illustrative quotes.

Results

The thematic analysis of both the Men's and Women's services data identified 'barriers' and 'facilitators' relating to both 'person-specific' and 'contextual' factors. Within these domains, seven main themes emerged from the Men's service focus group (Figure 1) and six main themes from the Women's service focus group (Figure 2).

[Figure 1 near here]

Men's Service: Person-Specific Barriers

Two main themes represented person-specific barriers: Conflicting Motivations and Fragmented Narratives.

Conflicting Motivations

Three subthemes were identified: Denial, Ambivalence about Moving and Risks of Destabilisation.

Denial: SUs denying the Index Offence was highlighted as a barrier to engagement since agreeing an offence was committed is fundamental to collaborative IOAF. Such SUs often feel frustrated at being detained and believe IOAF to be meaningless or incongruent.

> 'I've worked with people who've violently assaulted people but will say that did not happen so, of course, I do not need to be here […] I just need to be let out.'

Some SUs acknowledge the Index Offence but deny any need for IOAF, believing they will not re-offend and perceiving IOAF as unwarranted.

> 'People [SUs] feeling that we've not got any right to question the way that they have behaved.'

Ambivalence about Moving: Clinical Psychologists reflected that the safety of the MSU environment might be novel for some SUs, leading to ambivalence about returning to the instability of life outside secure care or engaging in steps towards discharge such as IOAF.

> 'Those people [SUs] might even say "I want to move on I want to get out" but actually kind of the factors that really motivate them are just to be cared for and here is the most cared for place they've ever been.'

Conversely, perceiving IOAF as an empathic process or one that could facilitate progress/recovery can create conflict for some SUs who believe they deserve punishment and detention. Such SUs may appear ambivalent to work thought IOAF towards discharge.

> 'Them [SUs] saying, "I deserve to be here, I need to be here for a really long time." So the idea of doing some process which is about understanding so you can move on is…[contradictory].'

Risks of Destabilisation: Clinical Psychologists reflected that IOAF is accurately perceived by many SUs as potentially destabilising; thoughts of deliberate self-harm can increase during IOAF and feelings such as shame and anger are often evoked. Consequently, IOAF becomes a

source of fear and avoidance is protective.

> 'It's so traumatising and I guess sometimes people [SUs] need quite a bit of time to actually come to terms with what they've done before they can even think about starting some of that work.'

Fragmented Narratives

Memory and communication difficulties affect SUs' ability to engage in IOAF: substance/alcohol misuse or acute mental health difficulties at the time of the Index Offence may have impaired encoding or consolidation of memories, whilst head injury or neuro-developmental disorders affect accurate retrieval and communication.

> 'If they [SUs] were very acutely unwell at the time their ability to recall [...] who people were and what they said, what they did in response, what they felt at the time. Might be really hard for them to access that.'

This emphasises the importance of using collateral sources of information in IOAF; however, this problem is exacerbated if SUs' files contain limited historical data to counteract the impact of fragmented narratives.

> 'There might not be other good accounts. They [SUs] might have been very isolated. There might be real lack of kind of quality information to build that information.'

Men's Service: Contextual Barriers

Two main themes represented contextual barriers: Prioritising Mental Health Symptoms Over Long-Term Risks and Resource Limitations.

Prioritising Mental Health Symptoms Over Long-Term Risks

Clinical Psychologists thought at times long-term risk factors could be overshadowed by mental health management and current symptom presentation, which could convey an implicit message to SUs about the importance of IOAF. Although important given the remit of the MSU, mental health was noted to be one of *many* factors relevant to understanding long-term risk.

> 'I'll miss a patient clinical review, come back, and find out someone's [SU] got leave and I'll think, well, what have they done in the last two weeks that means they're less risky, but it's that focus on stability of mental state rather than kind of more global progress.'

Resource Limitations

Two sub-themes were identified: Complexity versus Capacity and Stability of Wider Care

Team.

Complexity versus Capacity: The high ratio of SUs to Clinical Psychologists, and the time consuming nature of working in creative and flexible ways with people struggling to engage, also creates difficulties for IOAF.

> 'For me to take a couple of hours to go on leave with someone [SU] or whatever isn't really feasible but for some people that might be the only way they talk about something.'

Stability of Wider Care Team: Clinical Psychologists' ability to involve the wider care team in IOAF was seen to be limited by staffing pressures across the system. Frequent moving of care staff to wards 'in need' was thought to reduce care staff availability for joint working with Clinical Psychology that might enable understanding of IOAF.

> 'I tried to do that systemic work and people [staff] haven't turned up or haven't been able to turn up for training and actually you get a bit disillusioned and stop doing that indirect working.'

Concerns were raised that, as a consequence, SUs might experience varying approaches from care staff not familiar with SUs' individual psychological needs due to staff placement in areas outside their normal duties.

> 'If all your [SUs] other interactions with staff go against that [agreed psychological approach to meet SU needs] in terms of the spirit of them or the nature of those interactions, then you [Clinical Psychologists] may as well not bother. In fact, it's probably just confusing and counter-productive.'

Men's Service: Person-Specific Facilitators
Two main themes represented person-specific facilitators: Preparatory Work and Collaborative Process.

Preparatory Work
Two sub-themes were identified: Therapeutic Alliance and Skills Development.

Therapeutic Alliance: Clinical Psychologists spoke about the value of taking time to build trust and establish therapeutic relationships with SUs prior to commencing IOAF.

> 'Allowing people [SUs] the opportunity to build trusting relationships […] creates, you know, the best chance that you're going to be able to explore stuff where there are psychological barriers involving mistrust, paranoia, shame.'

Some SUs struggle to think about their Index Offence outside the context of their own

experiences of trauma and injustice, so acknowledging this aspect of SUs can be integral to creating the therapeutic alliance necessary to engagement in IOAF.

> 'The SUs seem to find it easier to begin the Index Offence work if you start with how it's affected them rather than straight in to […] you know their perpetrator role and risk management.'

Skills Development: Clinical Psychologists spoke about the importance of developing SUs' emotion regulation skills to prepare them for IOAF.

> 'What kind of preparatory work somebody [SU] would need to do before they can even get to that piece of work, and sometimes that isn't even psychology […] there can be all kinds of work that someone might do that would make it easier.'

This process can give Clinical Psychologists insight into barriers that could arise during IOAF and to adjust the process appropriately.

> 'A good clinical working knowledge of the service user is really good, and knowing what the impact might be when engaging this piece of work.'

Collaborative Process

Collaboratively agreeing the process of IOAF with SUs was agreed to be important. Such clarity is most effective as a facilitator if SUs' personal goals are aligned with those of IOAF.

> 'It's self interest things I think you often have to work with. Yeah, if your [SUs] goal is to leave and move in to the community then here's a plan how you can do that.'

Giving some choice and control over the process of IOAF facilitates engagement, including how to begin and when to focus on traumatic topics.

> 'I'm being quite transparent [with SUs] from the beginning that one of the things we [...] will need to talk about is the offending, but that might be one of the things we get to later.'

Men's Service: Contextual Facilitators

One main theme represented contextual facilitators: Links with the Wider Care Team.

Links with the Wider Care Team

Clinical Psychologists highlighted that involving the wider care team wherever possible in IOAF facilitates keeping long-term risk on the agenda.

> 'Actually just being in regular review meetings and making sure that both the rest of the team and the individual [SUs] keep that in their minds.'

Direct work on offending and risk was perceived to result in more proactive decision-making

by the care team, whilst conveying an implicit message to SUs about the value in IOAF.

> 'When we do it I think teams feel much more confident about taking proactive risks and moving
> people forward […]. They [SUs] do sometimes get a very clear message that this piece of work
> is really important to that.'

[Figure 2 near here]

Women's service: Person-Specific Barriers

Two main themes represented person-specific barriers: Protective Defences and Distorted Perceptions of Clinical Psychologists' Role.

Protective Defences

Two sub-themes were identified: Protecting the SU and Protecting the Clinical Psychologist.

Protecting the SU: Some SUs hold engrained, protective defences against the trauma of their Index Offence, often concealing an internal conflict between beliefs about being an offender and being a woman. Such SUs might lack motivation to engage in IOAF, fearing that removing these barriers will irreparably damage their sense of self.

> 'Women are seen as doubly bad and doubly dangerous and doubly shaming and we find that
> women are much more able to connect to their victimhood than their perpetratorhood.'

Clinical Psychologists reflected that removing these defences is not always beneficial for SUs.

> 'You can't just hold up a mirror and say this is what happened, this is what you [SU] did, you
> need to confront this. Because you might be doing much more damage.'

Protecting the Clinical Psychologist: Clinical Psychologists spoke about finding it challenging to hear details of SUs' Index Offences, sometimes manifesting as an underlying avoidance of this aspect of IOAF to protect themselves against vicarious traumatisation, for example, dreaming about victims.

> 'It's really hard for us to think about the victims and to be willing to go in the room and hear
> about how they died.'

Distorted Perception of Clinical Psychologists' Role

Two sub-themes were identified: Rejecting Clinical Psychologists and 'Using' Clinical

Psychologists.

Rejecting Clinical Psychologists: Linking IOAF directly with care pathways can leave some SUs feeling frustrated with Psychology at their lack of care pathway progression, which can damage the therapeutic relationship necessary for engagement in IOAF to enable care pathway progression.

> 'And then we contain all of the frustration, you know, of being detained then and that's the danger isn't it. Which doesn't make for a good therapeutic alliance.'

'Using' Clinical Psychologists: Clinical Psychologists highlighted that whilst some SUs appear to engage in IOAF, this is solely for care pathway progression rather than fully engaging with and benefiting from the process.

> 'You could go through all the steps and come out the other end having done it but really noticing lots of limitations in terms of their [SUs] ability in the reducing of risk, you know, their ability to really reflect on it.'

Women's Service: Contextual Barriers
One main theme represented contextual barriers: No Formal Guidance.

No Formal Guidance
The lack of published literature or formal service guidance on IOAF was highlighted, a problem for new Clinical Psychologists in knowing how to navigate IOAF.

> 'When I first came here I asked loads of people [staff] how to do it. I don't think anyone talked about it.'

Building guidelines for IOAF is problematic because of the variability of the process across SUs and the lack of a structured 'formula'.

> 'Everyone [staff] wants to know what the magic secret ingredient is and there isn't one. It's just a complex process of deciding what your focus is, you know, does it matter if they do or don't do it.'

Women's Service: Person-Specific Facilitators
One main theme represented person-specific facilitators: Flexible Approach.

Flexible Approach

Two sub-themes were identified: Collaborative Process and Creativity.

Collaborative Process: Clinical Psychologists highlighted that collaboratively agreeing the process of IOAF with SUs facilitates engagement. Negotiating timescales, mini-goals and any limitations of the work helps SUs feel safer about engaging in IOAF.

> 'Sometimes I give them [SUs] a timetable and I say when do you want holiday and they say, "Oh after we've done index offence that session where I'm talking about the index offence I want two weeks off." Alright then.'

Creativity: Using creative and tailored approaches to engage SUs in IOAF, helping to overcome feelings of shame in disclosing details of the Index Offence or other contextual events.

> 'We play mastermind games sometimes. […] Helps to get rid of the sense that I'm asking a question because I have got a specific agenda and, you know, putting a judgement on it.'

Women's Service: Contextual Facilitators

Two main themes represented contextual facilitators: The Service Valuing Long-Term Risk and Sufficient Capacity.

The Service Valuing Long-Term Risk

The importance placed on Clinical Psychology within the Women's service in understanding long-term risk was discussed; the wider care team understanding and valuing this role is integral to implementing IOAF.

> 'The team as a team believe that that is really important and would feel very uncomfortable about somebody [SU] moving on without having done, touched even, the Index Offence in any way.'

Explicitly linking IOAF with SUs' care pathways is effective in ensuring those SUs for whom risk is poorly understood do not progress to lower secure settings, thereby maintaining perceptions of the necessity of IOAF.

> 'There have been people [SUs] we haven't been able to work with [in IOAF], but that hasn't impacted upon their care pathway because they might have gone into another MSU or they might have gone up in security.'

Sufficient Capacity

The Women's service had the capacity to provide every SU with an assigned Clinical Psychologist from admission, facilitating the development of stable and trusting therapeutic

relationships as a solid base for engaging in IOAF.

> 'We have assigned Psychologists so from when the person [SU] comes in they build a relationship with their Psychologist. [...] With such challenging […] topics, having that therapeutic relationship is massively important.'

Discussion

We examined Clinical Psychologists' perceptions of barriers and facilitators to engaging SUs in IOAF within two medium secure services. The findings highlighted two main areas impacting upon Psychologists' ability to engage SUs in this process within their respective services: person-specific factors and the organisational context. Person-specific barriers appeared relatively similar across services: SU defences against the trauma of the Index Offence and associated negative thoughts/feelings were perceived to impact upon SUs' motivation to engage in IOAF. Offering clarity and choice to SUs and using creative approaches within the process of IOAF were highlighted as facilitators to engagement in both services, although the Women's service reported more scope for implementing these facilitators within the organisational context. The perceived impact of the organisational context on SU engagement with IOAF was clear: the Men's service Psychologists highlighted staffing resource issues and the perceived prioritisation of mental health presentation over long-term risks as barriers, while the converse were facilitators in the Women's service. It is of note that many of the factors identified by the present research may describe challenges to SU engagement in general within secure services.

The current findings highlight the therapeutic alliance as integral to facilitating SU engagement in IOAF in secure settings. In non-forensic settings, therapeutic alliance encompasses the level of collaboration, agreement of therapeutic goals and affective bond between clinician and SU (Gaston, 1990), and is associated with treatment outcome (Martin, Garske, & Davis, 2000). Such an alliance may be more difficult to achieve in secure settings where the service's aim to manage and reduce risk may not seem to SUs to correspond with their goals. Therapeutic alliance is closely related to the concept of relational security within secure settings, which is broadly defined as 'the knowledge and understanding we have of a patient and the environment, and the translation of that information into appropriate responses and care' (Jobbins et al., 2007), and associated with service satisfaction (MacInnes, Courtney, Flanagan, Bressington, & Beer, 2014). The challenge here is to create an effective therapeutic environment where SUs

also value risk management as part of their recovery and see relationships with professionals as a vehicle for achieving this, in part through collaborative IOAF. The Department of Health's (Department of Health, 2010) "See, Think, Act" guidance on relational security highlights how services should give patients realistic hope and belief in their recovery and allow them to build trust in those providing their care. Valuing and enabling the development of therapeutic alliance within secure settings from all organisational levels will be integral to engaging SUs in IOAF, and ensuring Psychologists have continued access to adequate supervision may be imperative in recognising problematic interpersonal dynamics interfering with the therapeutic alliance (Ackerman & Hilsenroth, 2003).

The current findings also highlight the level of staffing has implications for SU engagement in IOAF, perhaps because the perceived availability and accessibility of clinicians by SUs is thought to be integral to the therapeutic relationship (MacInnes et al., 2014). Poor availability or accessibility can be interpreted by SUs as disinterest (Johansson, Skärsäter, & Danielson, 2007), and so secure services must ensure that the level of staffing within secure services is aligned with recommended levels (Tucker & Hughes, 2007). The issue of adequate resourcing is pertinent given the government recommendation that mental health services should be 'providing services that meet the needs of SUs and their carers and make efficient use of resources' (Department of Health, 2007). Finally, the findings highlight the perceived benefits of offering clarity and choice to SUs within the process of IOAF to facilitate engagement. Receiving adequate information and feeling respected by staff are pertinent to building therapeutic relationships in MSUs (MacInnes et al., 2014), and so secure services may wish to consider including specific reference to IOAF within the written information available to SUs.

This study was perhaps unique in examining Psychologists' perceptions of barriers to engaging SUs in IOAF for *both* men and women. Although men represent a larger proportion of admissions to secure services (Nicholls, Brink, Greaves, Lussier, & Verdun-Jones, 2009), the comparative level of risk posed by women is often underestimated (Nicholls, Ogloff, & Douglas, 2004). Our findings suggest that the *same* factors are relevant to IOAF in secure services for men and women: whilst the organisational context differed across the two services, the person-specific factors highlighted by Clinical Psychologists were similar. Whilst further research is needed to clarify this finding, this highlights the importance of sharing information about IOAF across male and female secure settings.

Clinical Implications

The integration of IOAF into clear care pathways within secure settings may be integral to promoting SU engagement and improving our understanding of the long-term risks posed, particularly given the perceived benefits of aligning IOAF with care pathways in the Women's service as outlined here. Further research is required that clearly defines the process of collaborative IOAF. This could usefully develop on West and Greenall′s (2011) framework of offence analysis to consider how this process could best engage SU's in developing an understanding of the offence, whilst also recognising the limitations of the material they provide in gaining an objective understanding when compared to collateral information.

Better identification and awareness of barriers is the first step to facilitating engagement (Ward, Day, Howells, & Birgden, 2004), and our finding that there are an array of barriers to IOAF encompassing *both* contextual and person-specific domains indicates the need to establish a clear framework for the process of collaborative IOAF that can be used broadly across secure units. This would help ensure consistency across and within secure settings but should also allow scope for the creativity of approach identified by participants as being important for engaging SUs. A useful concept to contribute to such a framework may be that of 'treatment readiness', defined as the presence of characteristics within the SU or therapeutic context that promote engagement and thereby impact upon clinical outcomes (Howells & Day, 2003). Relevant frameworks already exist within forensic settings; the Multifactor Offender Readiness Model (Ward et al., 2004) outlines factors impacting upon engagement in psychological treatments encompassing both internal (e.g. cognition, affect and behaviour of SUs) and external factors (e.g. resources, location and timing). Although the evidence-base of psychological measures drawing on the MORM is limited (Mossière & Serin, 2014), the framework was recently adapted for specific populations using Delphi methodology (Tetley, Jinks, Huband, Howells, & McMurran, 2012). Delphi methodology incorporates feedback from a panel of experts in a series of iterations until consensus is obtained (Dalkey & Helmer, 1963; Rowe & Wright, 1999). Adapting this framework for IOAF within secure settings using similar methodological rigor may be beneficial to improving consistency and understanding.

This paper considers challenges to the process of collaborative formulation and acknowledges that others have argued for limiting offender involvement to providing a baseline account within

an analysis of the offence that is seemingly conducted purely by professionals (West & Greenall, 2011). However, the process of formulating collaboratively is potentially key to service user recovery and rehabilitation; the individual developing an understanding of past behaviour arguably forms a fundamental step towards living a life free from offending. Collaboration does not mean accepting, unchallenged, the initial accounts of SUs and joint review of collateral information is likely to form a central part of this work. Outstanding questions remain as to whether collaborative IOAF for recovery purposes needs to exist in parallel to more professionally determined Index Offence Analysis for risk management purposes (e.g. West & Greenall, 2011), or whether there is a means of integrating these. Good agreement between the two would indicate a genuine "shared understanding", the importance of which is emphasised as a step within the My Shared Pathway recovery-based approach to secure mental health care (Esan, Pittaway, Nyamande, & Graham, 2012).

Limitations and future directions

Whilst thematic analysis provides a richness of data, the scope of interpretation within qualitative analysis affects the reliability of results. Although an independent researcher was consulted regarding themes, a second coder would have provided a more robust approach. The small sample size and cross-sectional design based on only one MSU undoubtedly affects the validity of findings and limits the generalizability of the results. Furthermore, the study occurred at a time of significant reorganization across the MSU which could have impacted on the results, with further data collection points and multiple sites perhaps useful in future research.

Difficulty defining IOAF represented a significant challenge. Although there are similarities to West and Greenall's (2011) approach to Index Offence Analysis, there are also differences in terms of the level of SU involvement. Equally, although there are many similarities with psychological formulation in non-secure settings, IOAF navigates challenges which are arguably unique to forensic material. Better definition of IOAF, ideally involving agreement on a clear structure or protocol for this process, would increase the reliability of future research.

It would be useful for future research to establish how wide the practice of involving SUs in IOAF is within secure units and whether service protocols have been developed to facilitate this. It was beyond the scope of the current research to consider barriers to IOAF beyond those affecting SU engagement (e.g. availability of collateral information) and these are clearly

pertinent to the overall process.

Future research could address the limitations of the present study by exploring the costs and benefits to collaborative IOAF and consider questions such as: Do Psychologists involve SUs in collaborative review of collateral information, if so how and what are the benefit/challenges of doing so? Does level of engagement with IOAF help predict successful recovery? Can a genuine shared understanding of the Index Offence be achieved in secure services and does successful collaborative understanding have implications for risk management? Further research focusing on whether parallel understandings of the Index Offence (i.e. one developed through collaborative IOAF and one through professional analysis) as used would also be useful.

Conclusions

This study examined the perceived barriers and facilitators to IOAF within secure settings, and highlighted that *both* the organisational context and factors internal to SUs can impact upon Clinical Psychologists' ability to complete IOAF. Further research examining the process of IOAF and leading to the establishment of a standardised framework for IOAF that can be incorporated directly within clear care pathways through secure settings may be pertinent to promoting SU engagement and facilitating consistency of approach. This is important as engaging SUs in IOAF arguably provides a more comprehensive understanding of risk factors and a key step towards recovery where the goal is an offence-free lifestyle, which benefits both SU *and* the wider public.

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Figure Captions

Figure 1. Men's service themes.

Figure 2. Women's service themes.