An Evaluation of Joint Case Working on the Offender Personality Disorder Pathway

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Contents

Introduction

Note on Terminology

Within Yorkshire and the Humber Personality Disorder Partnership (YHPDP), Probation Service, and Leeds and York Partnership NHS Foundation Trust (LYPFT), the following terminology are used:

- Probation Practitioner (PP), *previously Offender Manager*
- People/person on Probation (POPs/POP), *previously Service User(s)*

The new terminology will be used throughout this report. However, at the time of ethics application and design and creation of evaluation materials, the original terminology was used and therefore may appear within the appendices.

Literature Review

The Offender Personality Disorder Pathway

The Offender Personality Disorder (OPD) Pathway is a jointly commissioned initiative by NHS England and the National Offender Management System, providing services for high-risk offenders with complex needs that are linked to personality difficulties (Joseph & Benefield, 2012; NOMS & NHS England, 2015). The pathway was launched in 2011 in response to findings from evaluations of its predecessor, the Dangerous and Severe Personality Disorder (DSPD) programme and the publication of the Bradley Report (Bradley, 2009). The findings identified concerns regarding the management of, and lack of support for, individuals with mental health difficulties and considered "high risk" within the criminal justice system, and thus the OPD pathway strategy was proposed (Joseph & Benefield, 2012).

A key component of the strategy is the 'pathway' element, referring to the need for offenders to be managed and supported at all stages of their respective journeys through the criminal justice system (Skett & Lewis, 2019). This includes provision of assessment and treatment within custodial settings through to continued community support upon release (Minoudis & Kane, 2017).

The overall aim of the OPD Pathway is to improve public protection and the psychological wellbeing of those on the pathway (high-risk offenders who have committed serious offences and have traits consistent of those linked to personality disorders and difficulties).

These aims are achieved through measured outcomes such as a reduction in recidivism, increased competency and confidence of the workforce, and the delivery of cost-effective yet high-quality services (NOMS & NHS England, 2015). To achieve these aims, the pathway's underpinning principles include adopting a psychologically informed approach with promotion of formulation-based assessment and treatment, and regular evaluation.

Consultation on the Pathway

One of the key OPD pathway aims relates to improving the knowledge and competence of the workforce, including both NHS and HMPPS staff (Joseph & Benefield, 2012). It was recognised those working on the pathway should understand the interplay between personality disorders and offending behaviour, and the subsequent impact on risk and interpersonal behaviours, by adopting a trauma-informed lens (Skett & Lewis, 2019). One way of achieving this is via case consultation.

Case consultation within the OPD pathway refers to the process of collaborative discussion and reflection between a PP and a Clinician (Clinical Psychologist, Forensic Psychologist, or Psychotherapist). PPs are responsible for managing large caseloads of high-risk POPs' with complex needs, a degree of whom may be screened onto the OPD pathway, and who may present with challenges such as non-engagement or lack of progress with their identified plan (NOMS & NHS, 2015). The aim of case consultation is to develop a greater understanding of POPs difficulties through creation and usage of a psychological formulation and to manage their risk and needs going forwards via pathway planning. For PPs, case consultation can allow the time and space necessary to adopt a greater psychological understanding of POPs' presentation, increase confidence working with personality-related difficulties, and enhance trust and rapport with POPs (Shaw et al. 2017).

Research into case consultation has mainly sought to understand the impact from the perspective of the PP. In one study, PPs were asked to complete a questionnaire at three timepoints; prior to and immediately after a case consultation (individual or group) and following receipt of a formulation letter several weeks later (Knaeuer et al. 2017). Following the consultation, PP's self-rated scores were significantly higher on subscales related to their knowledge of the POP's case; confidence and motivation to work with the POP; and satisfaction regarding future case management and pathway planning. Interestingly, ratings did not significantly improve further following receipt of the formulation letter, perhaps

suggesting benefits were a direct result of the consultation itself. Results were discussed in the context of workforce development, in that PPs felt more confident working with the individual POP case discussed, but also others on their caseload and the wider client group (Knaeuer et al. 2017).

Elsewhere, case consultation has been described as "validating" for PPs as it alleviated fears or concerns about individual POP caseloads (Blinkhorn et al. 2020). The research also found that PPs valued the space to have open and non-judgemental conversations, feeling this facilitated their understanding of risk, relational difficulties, and the impact of previous life experiences when presented as a formulation.

Commissioner Service Description and Joint Case Working

YHPDP is a regional service, delivering OPD pathway services across Yorkshire and Humberside, comprising staff from the Northeast National Probation Service and LYPFT. The partnership is community-based and offers a framework of consultation and training to PPs working with POPs on the pathway (Snodgrass & Lowton, 2017). This work is in line with the aforementioned aims of the OPD pathway (Radcliffe et al. 2020).

Three strands of work are grouped under the consultation offered by YHPDP (YHPDP, 2021). Firstly, there is case consultation, where PPs are supported to understand and formulate the risk, behaviours, and relational presentations of POPs, and engage in pathway planning via a psychologically-informed approach. This is in the format of clinicians meeting with PPs individually and results in developing or updating a core formulation.

The second strand involves the consultation of emergent themes and issues, which can result from direct requests from PPs for learning in relation to a particular topic, as well as consideration of more general gaps in knowledge. Typically, this might take the format of group reflective practice or provision of psychoeducation to teams, with a focus on workforce development.

The final strand of consultation offered by YHPDP is that of joint case working (JCW). JCW is defined as a way of clinicians being more actively involved in supporting community case management and is viewed by the partnership as "*existing within, rather than outside of, our consultation framework"* (YHPDP, 2021, p.5). JCW does not refer to the provision of direct therapeutic work or intervention with POPs. JCW involves higher intensity input than

case consultation alone and is therefore designed to be reserved for POPs with higher levels of complexity or risk (YHPDP, 2021).

Within the OPD pathway strategy documentation, descriptions of JCW are brief and it has been noted that there are several roles in which the PP and POPs may adopt (Snodgrass, 2017). Within YHPDP, a potentially wide range of activities might be defined as JCW, including those where there is no contact between the clinician and POP, as well as those where there is some level of contact. For the former, examples include supporting attendance at meetings, undertaking caseload reviews, supporting a PP to incorporate a formulation into reports, and helping the PP to plan sessions with POPs. The latter might include activities such as writing a letter to a POP or supporting the PP at sessions and meetings with POPs.

Within YHPDP, previous evaluation and research have focused predominantly on the first strand, case consultation. For example, a pilot study asked 44 PPs to rate their confidence and competence working with POPs on the pathway, before and after case consultation (Ramsden et al. 2014). Post-consultation, PP scores were significantly higher for their understanding of personality disorder, feeling equipped with the necessary skills to work with POPs, and more positive feelings about doing so. It was acknowledged that not all PPs returned scores post-consultation, and those who did may have done so due to having positive experiences; however, this does provide preliminary support for the effectiveness of case consultation in the region (Ramsden et al, 2014).

A recent qualitative study explored the experience of PPs who had participated in at least three formulation-based consultations within the service (Radcliffe et al, 2020). Pre-consultation, PPs reported feeling overwhelmed at managing complex, high-risk and emotive cases. PPs described the consultation itself as a protected space, allowing enough distance from the individual case to consider trauma history, current presentation, and interpersonal behaviours via the formulation. PPs reported altering their practice as a result by approaching interactions with POPs in new ways, which improved engagement and interactions. Additionally, PPs believed these changes were generalisable to wider practice, not confined to the single case discussed; some also believed that they could pass on psychological understanding to their colleagues. Potential difficulties of case consultation

were highlighted, such as whether time and resource pressures would allow for consistent meetings and whether it would become blurred with supervision (Radcliffe et al, 2020).

Within the service, evaluation of case consultation alone has highlighted many benefits and suggestions, consistent with those in the wider literature. As of yet, the third strand, JCW, has not been evaluated, and therefore little is known about how much of this type of consultation is being done, in what format, and *both* PP and clinician views of this.

Aims

This project aims to evaluate JCW within YHPDP. Specifically, the evaluation aims to address the following:

- How much and what type of JCW are clinicians/PPs doing?
- How valuable is JCW perceived to be?
- What do clinicians/PPs find useful about JCW?
- Does this type of working put psychologically informed formulations into practice?
- How are decisions made about who is offered JCW?
- Are there barriers to JCW?

Method

Design

The evaluation adopted a mixed-methods approach, through quantitative analysis of responses to an online survey and rapid qualitative analysis of interview responses. This method was selected to provide an overview of clinician and PPs views and engagement with JCW (via the survey), and more in-depth exploration of the impact, benefits, and barriers (via the interviews).

Survey

An online survey was created and hosted on Online Surveys, containing six questions (see Appendix A). One question varied slightly depending on the respondent's job role. The survey contained a mixture of Likert scale, multiple-choice, and free-response questions, taking approximately ten minutes to complete. This sought to address aims related to *how much* and *what type* of JCW PPs and clinicians are doing.

Interview

Topic guides for interviews were devised to address aims related to *how valuable, applicable, and impactful* JCW is perceived to be. The topic guide consisted of six key questions with additional prompts dependent on the respondent's job role (see Appendix B).

The survey questions and topic guide were discussed and agreed in collaboration with the commissioner.

Recruitment

An email was circulated by the commissioner to potential participants (a staff group consisting of PPs and clinicians working within the region, who had participated in JCW). The email asked interested participants to complete the online survey (see Appendix C). Within the email and at the end of the survey, participants were invited to contact the Psychologist in Clinical Training if they were also interested and willing to take part in a short interview regarding their experience of JCW.

Additionally, the project was introduced and discussed within the YHPDP Research Strategy Group and monthly team meetings to enhance responses.

Ethical considerations

Ethical approval was granted by the University of Leeds School of Medicine Ethics Committee (DClin REC21-004) on 13/01/22 and HMPPS (2022-017) on 26/04/22.

For the survey, both the participant information sheet and consent form appeared on Online Surveys, with participants required to provide informed consent before proceeding to the questions. For the interview, interested participants were emailed a copy of the participant information sheet and a link to a consent form (via Online Surveys) prior to the interview date.

The online survey did not collect any personally identifiable information and therefore anonymity of respondents was maintained.

Interviews took place on Microsoft Teams, with recordings securely stored on the University OneDrive. It was not anticipated that any criminal or other disclosures would occur,

however participants were reminded of the need to keep responses anonymous and asked not to disclose any identifiable information (such as specifics relating to POPs).

Analysis

Descriptive statistics were obtained for responses to the survey and graphs created in Excel.

Interviews were analysed using Rapid Qualitative Analysis. This type of analysis recognises the need for rapid turnaround of implementation research within health services, to assist with answering 'how and why' questions and to provide real-time feedback and recommendations to services (Hamilton, 2013; Hamilton & Finley, 2019). It is a pragmatic approach that prioritises the identified aims of the evaluation. Steps differ to other forms of qualitative analysis; for example, transcription is not required, and analysis can occur whilst data collection is ongoing.

The first step involves creating a template summary for each interview, in which domains are created that link to each interview question (for example, 'Benefits of JCW' and 'Barriers of JCW' are examples of two domains; see Appendix D). Summaries were completed for each interview whilst listening back to the recording. Following this, summaries were collated to form one 'matrix summary' which allows for a more streamlined overview of all interviews to begin to identify themes within the data. Three matrix summaries were created: one for PPs, one for clinicians, and one combining the two. This allowed for an overview of key themes within each domain and to identify similarities and differences.

Results

Survey

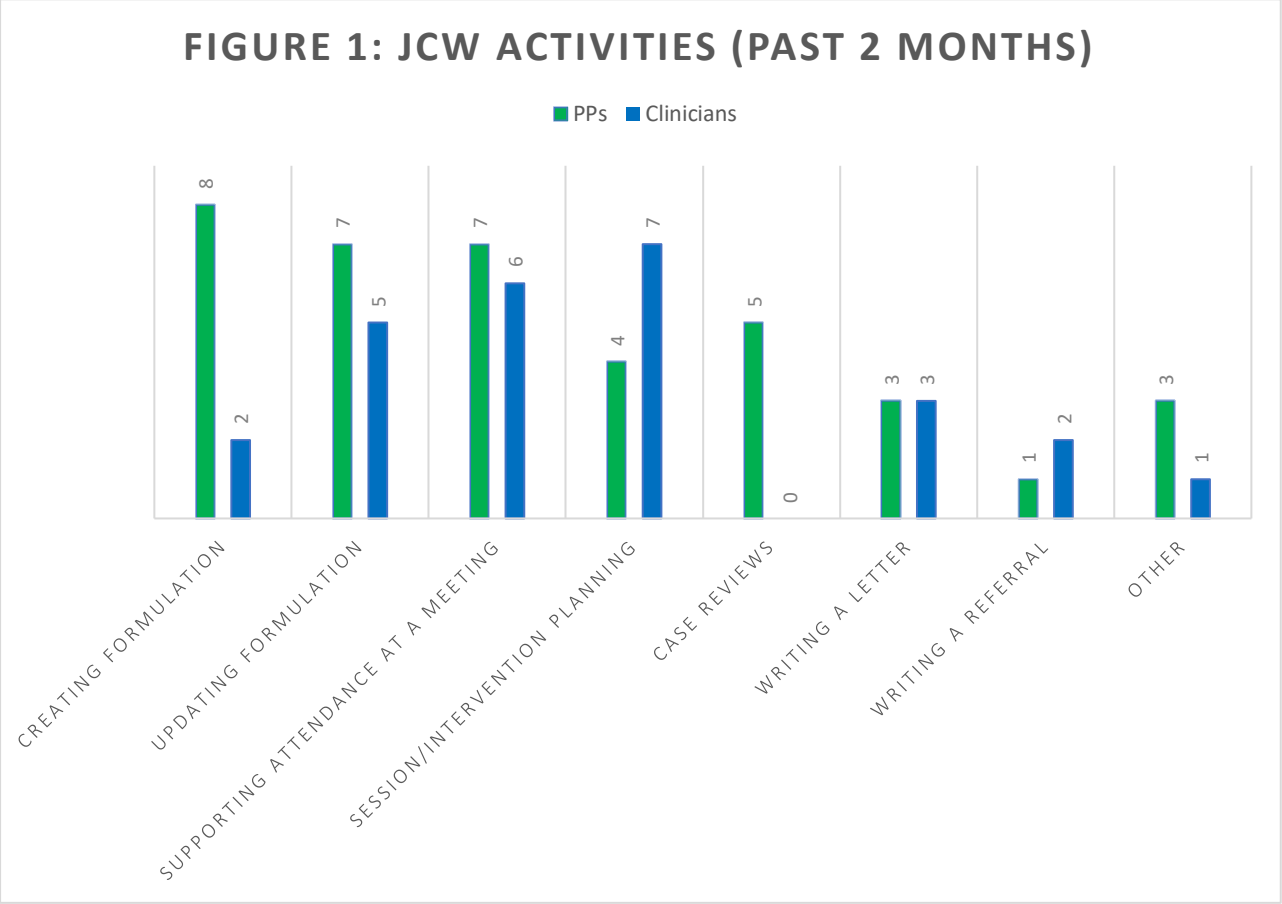
13 PPs and 9 clinicians responded to the survey. PPs length of time within their role ranged from 11 months to 20 years (mean 8 years); clinicians time within role ranged from 10 months to 5 years and 6 months (mean 2.5 years).

JCW Activities

Participants were asked how many contacts they had had over the past two months that they would define as JCW. PPs responses ranged from 1 to 100, although when this figure of

100 was removed as a potential outlier, responses ranged from 1 to 8 (mode 2, mean 2.5). Clinician's responses ranged from 0 to 9 (mode 3, mean 3.6).

Participants were asked to select the type of activities that this involved, selecting more than one response if appropriate. Results are displayed in Figure 1 below.



The majority of PPs had been involved in creating a formulation (*n*=8, the most endorsed PP activity) and updating a pre-existing formulation (*n*=7). Clinicians had been involved more often in updating a formulation (*n*=5) than creating one (*n*=2).

Similar numbers of PPs and clinicians had supported attendance at meetings (*n*=7 and *n*=6 respectively) and writing a letter (both *n*=3).

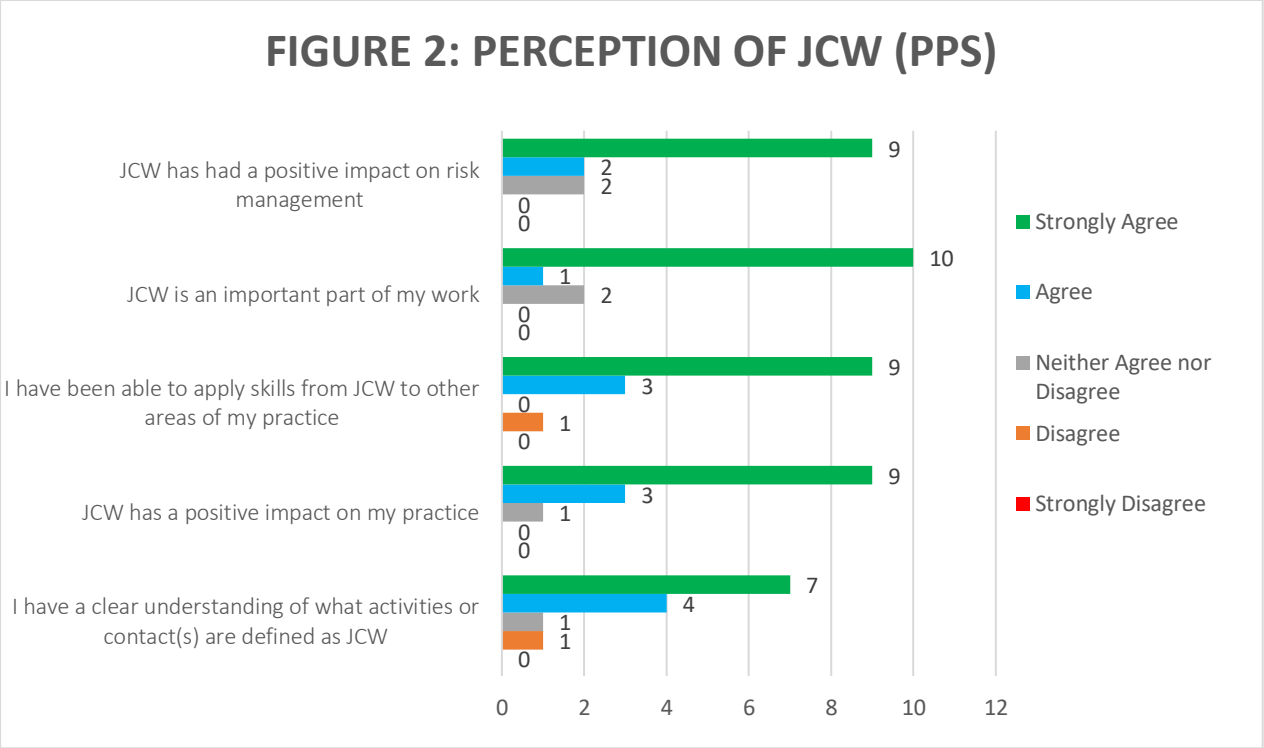
The least endorsed JCW activity amongst PPs was writing a referral (*n*=2). No clinicians had been involved in case reviews, compared to five PPs who had. The most endorsed activity for clinicians was session/intervention planning (*n*=7).

Involvement in 'other' activities included undertaking joint work with a HIPP Psychologist; meeting with a POP to work on relational difficulties; and completing child protection reports (PPs); and co-facilitating a community afternoon on the HOPE Progression unit (clinician).

Perception of JCW

Participants were asked to rate their agreement of several statements related to their experience of JCW.

The results for PPs are in Figure 2 (below).

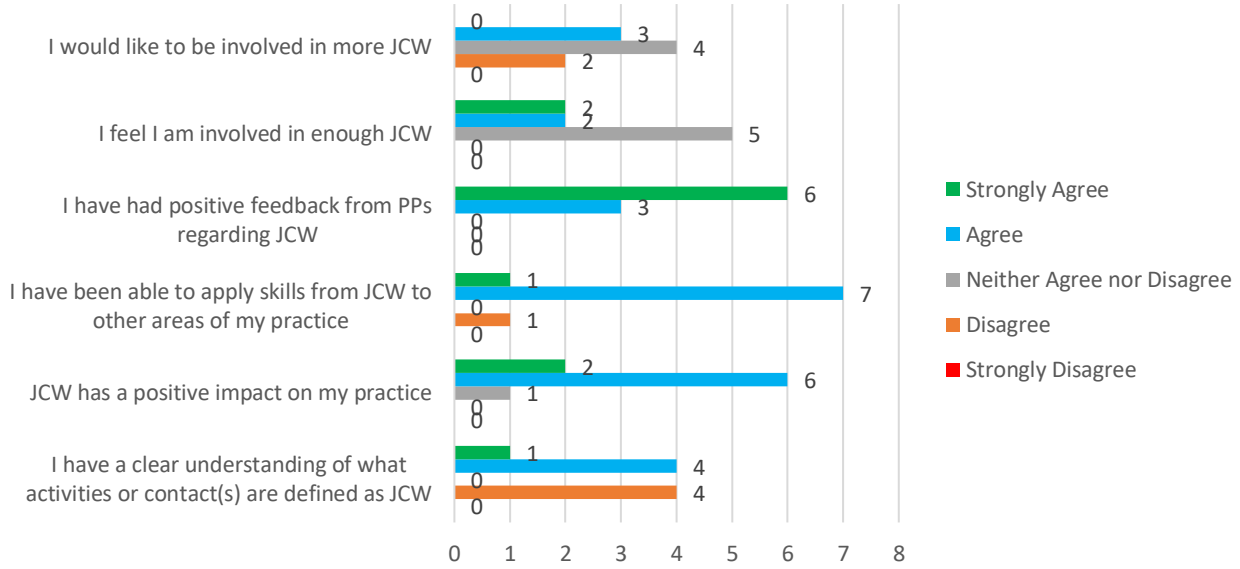


The majority of PPs strongly agreed that JCW has a positive impact on risk management and practice, JCW is an important part of their work, and they can apply skills from JCW to other areas of practice.

Fewer participants strongly agreed that they had a clear understanding of what is defined as JCW.

The results for clinicians are in Figure 3 (below).

FIGURE 3: PERCEPTION OF JCW (CLINICIANS)



All clinicians strongly agreed or agreed that they had received positive feedback from PPs regarding JCW, and most strongly agreed or agreed that they were able to apply skills from JCW to other areas of their practice and that it had a positive impact (one disagreed with the former, one neither agreed nor disagreed with the latter).

Responses were mixed regarding understanding of JCW, with one clinician strongly agreeing, four agreeing, and four disagreeing.

Barriers

Participants were asked to select from a list which barriers they had experienced related to JCW. For PPs, eight reported a lack of time, one a lack of resources, and one a lack of opportunity for contact with a clinician. For clinicians, three reported a lack of time (one stated this to be more for PPs than themselves) and none reported a lack of resources or opportunity for contact.

Within the free-response box, five PPs and two clinicians stated there to be no barriers to JCW. One clinician commented on changes to PP staffing which halted or delayed planned JCW.

Interviews

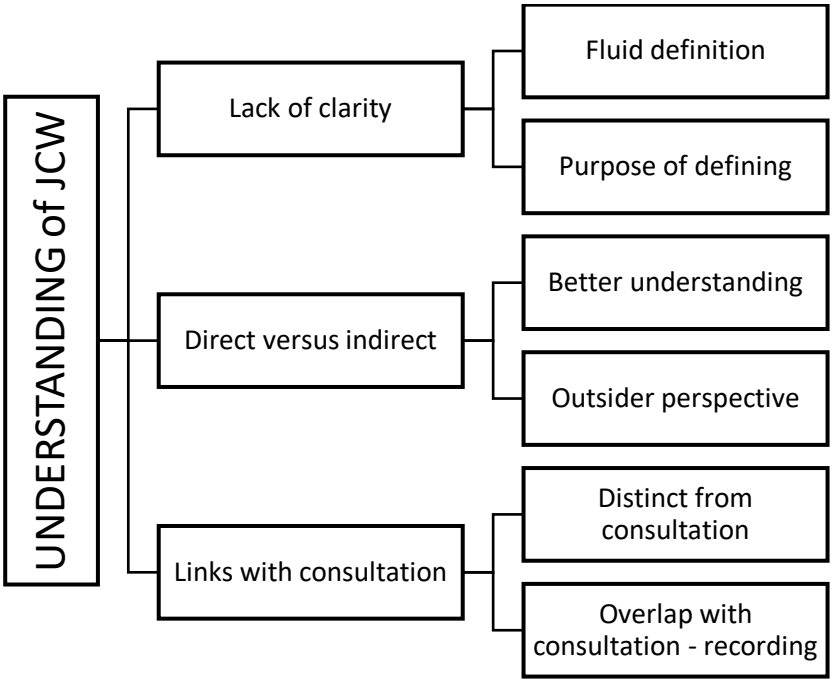
Four PPs and four clinicians (three Senior Forensic Psychologists and one Forensic Psychologist) were interviewed.

Themes were identified under each of the four main domains related to JCW; understanding, impact, benefits, and barriers (see Appendix E for full quotation table).

Understanding of JCW

Within 'understanding' were three major themes (see Figure 4).

Figure 4: Understanding of JCW – Themes and Subthemes



Lack of clarity

Clinicians in particular spoke of a lack of clarity as to the definition of JCW, particularly regarding the activities it involves and differences between YHPDP and CORE-OM guidance; it was referred to as a **fluid definition** in this sense.

Clinicians spoke of contrasting views relating to the need to define JCW more explicitly, considering what the **purpose of defining** it would be; for example, whether it is because they should be engaging in more direct JCW or because it is currently hard to quantify JCW activities.

Direct versus indirect

Clinicians and PPs spoke of a distinction between **direct versus indirect** types of JCW, with 'direct work' (joint meetings with the PP, clinician, *and* POPs) being less common.

Clinicians had differing opinions on whether directly meeting and working with POPs as part of JCW would be helpful. Those who had not done so believed this allowed a sense of neutrality, coming in with a fresh **outsider perspective** not based on preconceived ideas. PPs believed JCW worked effectively in an indirect format, without the clinician ever meeting the POP.

However, the one clinician who had engaged in this type of JCW believed it allowed them to get a **better understanding** of the relational dynamics and interpersonal challenges between the PP and POP.

Links with consultation

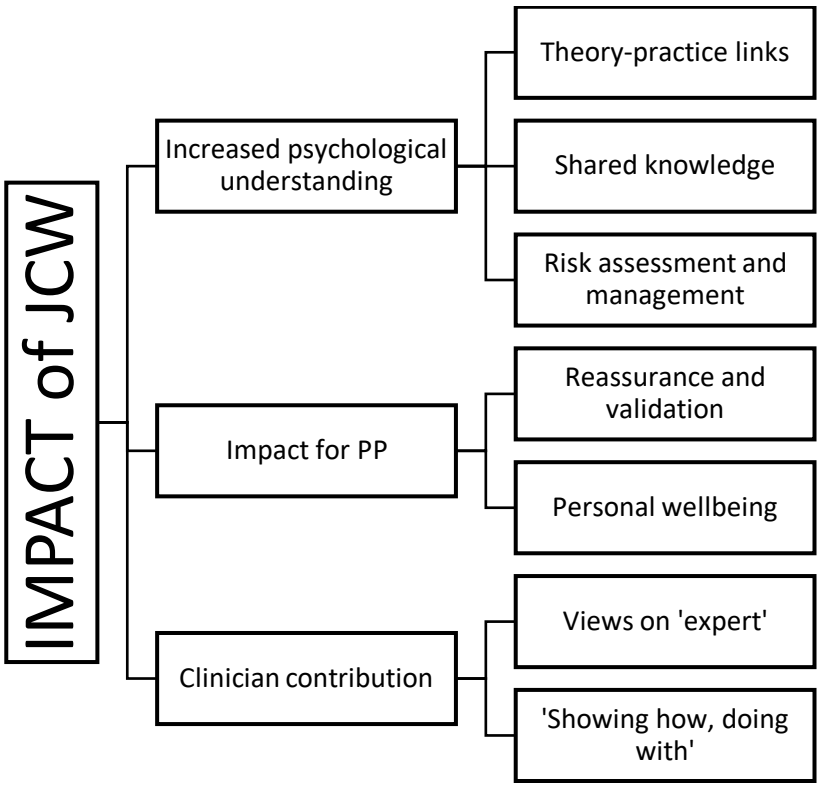
Both clinicians and PPs discussed their understanding of JCW in the context of **links with consultation**. For some, it was felt that JCW added "something extra" and allowed for an increased understanding and awareness.

Clinicians commented on JCW activities being recorded as consultation alone. Due to this **overlap,** it was acknowledged how difficult it might be to distinguish between them. Indeed, one clinician said they would rarely define work as JCW, unless it involved an additional element such as joint letter writing or attending a meeting with the PP.

Impact of JCW

Within 'impact' were three major themes (see Figure 5).

Figure 5: Impact of JCW – Themes and Subthemes



Increased psychological understanding

Clinicians and PPs believed JCW resulted in an increased psychological understanding. Clinicians incorporated **theory-practice links** to facilitate the PP's understanding of POPs; for example, by adopting a trauma-informed approach or considering the diagnostic criteria of personality disorder to explain traits and behaviours. PPs valued this psychological thinking and **shared knowledge,** especially in the context of understanding challenging behaviours.

An increased psychological understanding was recognised to have a positive impact on **risk assessment and management.** Clinicians spoke of the value of using formulation as an explanatory framework for PPs, to avoid taking risk at "face value" and losing sight of the potential change to dynamic risk.

PPs believed that risk-focused formulations helped them to identify when things were "going downhill" and allow them to recognise opportunity to intervene.

Impact for PP

Both groups believed that JCW provided the opportunity to **validate** the complex and challenging work that PPs do and "unpick" their difficulties with POPs. PPs described often feeling that POPs' lack of progression or engagement was their fault, but how **reassuring** it was to consider other influencing factors which reduced their sense of self-blame.

PPs commented on the impact to their **personal wellbeing,** believing JCW allowed them the opportunity to reflect on their work and their interpersonal interactions with POPs, to improve relationships and work together going forwards.

One clinician described the importance of PPs' reflexivity in being able to think about what they "bring as individuals" to their work, although acknowledged the importance of maintaining boundaries ("JCW, not supervision").

Clinician contribution

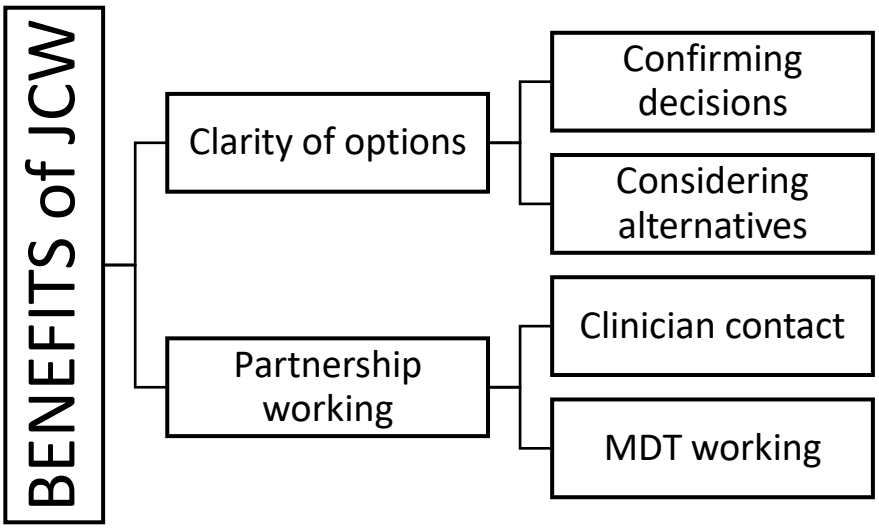
Clinicians mostly spoke of JCW in the context of the PP and what they offer, leading to differing views on **the expert.** Clinicians believed they were a "resource" for PPs, at times not feeling they added anything to the knowledge already held. In contrast were PP's comments about the expertise and professional opinion provided by clinicians.

Both groups believed JCW involved an element of **"showing how, doing with",** with clinicians guiding PPs to consider the application of concepts or suggestions to their practice and future work. For some, this was perceived to be a beneficial aspect of JCW not experienced elsewhere (such as within case consultation alone).

Benefits of JCW

Within 'benefits' were two major themes (see Figure 6).

Figure 6: Benefits of JCW – Themes and Subthemes



Clarity of options

Both PPs and Clinicians believed JCW allowed for greater **clarity of options.** PPs were able to discuss ideas or options for future work and pathway planning for POPs, allowing them to leave with "one definite option".

Additionally, PPs believed that engaging in JCW allowed them to **consider alternative options.** PPs referenced Discovery and how they had previously known little about it as a route for POPs. However, having the opportunity to discuss this with a clinician and receive assistance with referring POPs had been invaluable. Clinicians also recognised that they helped PPs to feel "less stuck".

Partnership working

PPs valued **clinician contact,** finding the team approachable, easy to contact, and quick to arrange meetings with. Clinicians acknowledged the unique position of working in partnership whilst recognising the challenges this can bring, such as considering needs from differing organisational perspectives.

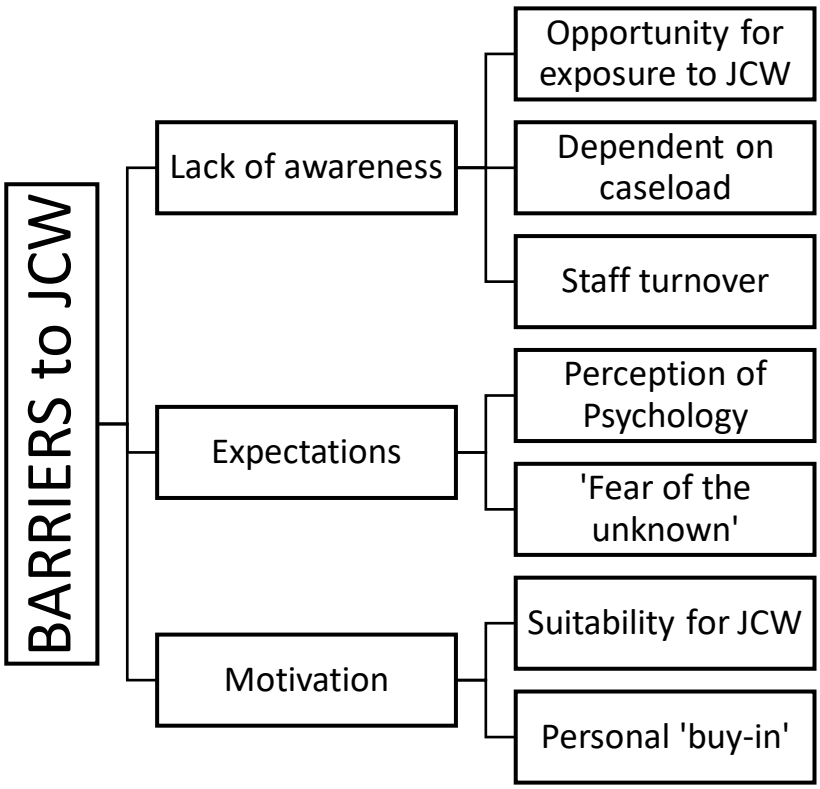
Clinicians valued **MDT working,** believing that teams coming together to make decisions regarding POPs facilitated understanding of the case and prevented decisions being made "in silo". One PP provided an example of how MDT working benefitted their practice, when

the clinician invited a social worker to a joint meeting with the POP to enhance relational understanding for all involved.

Barriers to JCW

Within 'barriers' were three major themes (see Figure 7).

Figure 7: Barriers to JCW – Themes and Subthemes



Lack of awareness

PPs and clinicians believed JCW was under-utilised due to a lack of awareness amongst probation staff. PPs had not been informed of JCW during their training, only becoming aware via **opportunities for exposure to JCW** such as shadowing another PP or through "word of mouth". Additionally, PPs believed awareness of JCW would be **dependent on caseload;** for example, if working with many POPs who were screened onto the OPD pathway.

Clinicians discussed attempts to promote awareness to probation staff, however this was accompanied by the recognition that there is a **high staff turnover** amongst probation and

therefore it may be difficult to establish ongoing, longer-term JCW. One clinician reported they had perhaps not been "directive" enough with JCW and its offers.

Expectations

Both PPs and clinicians discussed whether expectations of what JCW may involve influenced the lack of uptake. PPs believed the lack of awareness and unfamiliarity of JCW could result in a **"fear of the unknown".**

Clinicians also discussed whether **preconceived ideas** about working with Psychologists acted as a barrier. One clinician spoke of overcoming this by giving PPs a "taste" of what this looks like via conversations or more informal psychological input.

Motivation

PPs recognised their own **personal "buy-in"** to attend as a facilitating aspect and discussed reasons why some might not be motivated to attend as a barrier. It was queried as to whether this was part of a culture for both PPs and clinicians, in that "No-one does that, so I won't" or perceiving it as a "tick-box" exercise.

Clinicians emphasised JCW as focusing on a specific issue raised by the PP, and how challenging it could be when there was a **lack of suitability** for attending. This was typically related to cases where the PP had not yet met the POP on their caseload.

Discussion

This project aimed to evaluate JCW within YHPDP; specifically, what is classed as JCW and how much is being done, and the impact, barriers, and benefit of this work, from the perspective of PPs and clinicians.

A consistent theme within the present survey was the lack of clarity regarding the definition of JCW. As suggested by clinicians, this is perhaps due to varying guidance and recording of JCW (at times being more closely aligned with probation data or recorded as consultation only on clinical systems). Although both groups agreed JCW involves something "extra" than consultation alone, some overlap was evident within interviews. As a result, it was difficult to ascertain exactly how much JCW participants were involved in, although the survey

results showed an average of 2.5 and 3.6 contacts for PPs and clinicians respectively (in the past two months). However, the number of contacts for other types of consultation were not collected and could not be compared, which is acknowledged as a limitation.

The lack of clarity regarding the definition is likely to be linked to the lack of awareness of JCW reported as a barrier by both groups-for example, if PPs are not clear on what JCW involves and there is a "fear of the unknown", they may be less likely to seek out or engage in this type of work. Some PPs had shadowed colleagues in JCW sessions during their training and recognised how helpful this had been to promote understanding. Therefore, enhancing shadowing opportunities for those in training or newly qualified probation staff might be considered, where possible. Additionally, clinicians acknowledged that, although they tried to maintain regular contact with probation teams, they were perhaps less directive about the usage and benefits of JCW; uncovering the "unknown" may reduce uncertainty and promote uptake.

There was a distinction between direct and indirect examples of JCW and the benefits of each. Some believed JCW should only be counted as such if direct contact with the PP and POP occurred, the benefit of this being an opportunity for the clinician to directly observe the dynamics and interactions. However, most clinicians and PPs believed that indirect contact allowed for impartiality, more objective discussion, and a fresh perspective of POP cases. Indeed, JCW documentation has recognised the complexities of the triadic relationship between PPs, POPs, and clinicians, due to the varying roles that each may occupy at any given time (Snodgrass, 2017). Such complexities may suggest that the POP is not present for all JCW contacts, given the benefits and impact that can occur.

Most clinicians and PPs agreed that JCW had a positive impact on their practice. Within interviews, PPs discussed the increase in psychological knowledge related to their cases, and clinicians believed JCW allowed them to understand POPs in more detail. Interestingly, although clinicians recognised the psychological knowledge they contributed, they were keen to reiterate the PP as the expert of the case and therefore viewed themselves as more of a resource.

Although clinicians were able to recognise the impact of JCW for PPs and POPs, they also acknowledged the difficulty in explicitly identifying areas of change or quantifiable

outcomes. Some clinicians had never sought feedback about their input to JCW, which could lead to a lack of understanding as to what is most helpful for PPs or indeed POPs.

Although the impact for POPs was not a key theme, the increased psychological understanding and implementation of formulation-based knowledge recognised by PPs was considered to impact those on their caseload. This related to the risk assessment, management, and pathway planning for POPs. Additionally, PPs spoke of their concerns or difficulties being validated and explored, allowing them to communicate more effectively with POPs on their caseload.

A notable barrier to JCW was a lack of suitability or aim for the work. JCW is an extension of consultation and therefore overlap is not unexpected, however a quality outcome of JCW is defined as "*the situation prompting the decision for JCW is achieved"* (Snodgrass, 2017). Indeed, clinicians believed that JCW was most effective when PPs attended with a clear aim or required action, otherwise it could be unclear why JCW was required. Therefore, prior to meeting, it may be helpful for the aim of the work to be explored to clarify whether case consultation alone or JCW is most appropriate.

Of note is how valuable JCW was for PPs who highlighted many areas of good practice. When questioned about barriers, PPs commented on how there was currently little that did not work or may be improved. Clinician comments were related mostly to practicalities, such as a high turnover of probation staff decreasing the opportunity for long-term work, as opposed to JCW content itself.

Recommendations

Based on the results, a number of recommendations have been suggested (see Table 1 below).

Table 1: Service Recommendations

Findings from evaluation	Suggested recommendations
1. Lack of clarity about JCW and the activities classed under the definition.	YHPDP may consider revisiting guidance on JCW from 2017 and 2020 and gather feedback from both clinicians and probation staff regarding the accessibility

	and understanding of the definition, and whether it captures their experiences of JCW in practice.
2. Difficult to know how much JCW is being done.	Consider how JCW activities are being recorded on both NHS systems and probation systems, and whether these accurately reflect the activities within JCW sessions.
3. Lack of awareness about opportunities for JCW.	To continue promoting JCW to PPs via briefings or training sessions, particularly considering how awareness may be emphasised for probation staff in training or those who are newly qualified.
4. No formal feedback or outcome measures collected at this stage.	To consider feedback sheets for PPs to complete following JCW sessions about what works well, perhaps in the form of free-response or open-ended questions. To also consider incorporation of more standardised outcome measures, for example those reflecting knowledge and understanding of personality difficulties, or confidence working with this client group (as in previous evaluations or research into the OPD pathway workforce).
5. At times, a lack of clear aim or desired outcome for JCW.	To consider clarifying the aims or desired outcome of the session ahead of meeting in order to determine whether JCW is the most appropriate type of consultation required at this stage.
6. Both PPs and clinicians valuing the opportunity to be involved with JCW	To continue promoting and undertaking JCW within the service.

Strengths and Limitations

A notable strength is that this is the first evaluation of JCW within YHPDP and provides the service with an overview of current areas of good practices and key recommendations.

It is important to acknowledge that this evaluation represents only a small sample of self-selecting PPs and clinicians working within the region, and therefore may not be representative of all perceptions of JCW within YHPDP or indeed OPD pathway services. A sampling bias may be evident, in that those with more positive experiences of JCW may have volunteered to participate more readily.

It is acknowledged that data collection and analysis were undertaken by the Trainee Clinical Psychologist alone, however results and themes were discussed with the commissioner and the likelihood of bias was potentially reduced due to the Trainee not working within YHPDP.

The rapid qualitative analysis utilised focuses on the content of interviews as opposed to in-depth exploration of links and rich interpretation, however this was appropriate for the purpose and aims of this evaluation. Future research may seek to explore JCW within the service in more depth or via alternate methods.

Although not explicitly derived as a theme, the impact of COVID was referenced within interviews and therefore the above findings and recommendations should be considered in the context of

a) Limited face to face contact between probation and clinical teams;
b) Increased staff sickness rates; and
c) Adjustments to new ways of working.

Dissemination

- The results have been shared with the commissioner and are due to be discussed within upcoming YHPDP meetings.
- The project was presented at the University of Leeds SEP poster and presentation conference in October 2022.
- An end-of-research report will be provided to HMPPS.

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Appendices

Appendix A: Online Survey

An Evaluation of Joint Case Working on the OPD Pathway

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Information Sheet and Consent

Thank you for expressing an interest in taking part in this Service Evaluation Project. On this page, you will find **information** about this online survey and, should you wish to take part, a **consent box** at the bottom of the page.

Joint Case Working within the Offender Personality Disorder Pathway

You are being invited to take part in an evaluation. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you have any concerns or would like to discuss the project further, please contact the individual whose contact details are listed at the bottom of this information.

What is the purpose of the evaluation?

This evaluation seeks to evaluate joint case working within the Yorkshire and Humberside Personality Disorder Partnership, as part of the Offender Personality Disorder pathway.

Why have I been chosen to take part in the evaluation?

You have been chosen to take part in this evaluation because you currently work as either an Offender Manager **or** NHS Clinician within the Offender Personality Disorder pathway and have been actively involved in work categorised as "joint case working".

What will I have to do?

We would like you to answer questions on an online survey. The online survey will contain a mixture of questions, and it should only take approximately 10 minutes of your time to complete.

What will happen to the information I provide?

All of the answers you provide to the questions will be anonymous (i.e. there will be no way to link the answers you have provided back to you). All answers will be collated by the lead researcher. The responses provided will be used to inform a written report. The report will include recommendations and suggestions based on responses to the online survey.

For more information on how your information is used for research within the University of Leeds, please see the following: http://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf

Do I have to take part?

Taking part in this evaluation is entirely voluntary. If you do decide to take part, you will be asked to sign a consent box at the bottom of this page in order to proceed with the online survey. If you wish to withdraw at any time, you may do so by closing the survey window down. However, once you have completed the survey and your responses have been submitted, you will be unable to withdraw your responses as these are anonymous and therefore unable to be traced back to you.

What are the possible disadvantages and risks of taking part?

It is not anticipated that there will be any risks or disadvantages to your participation.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those who participate, it is hoped that this evaluation will enhance an understanding of joint case working within the OPD pathway. The results of this evaluation will be used to make recommendations and suggestions for future OPD pathway working.

Use, dissemination, and storage of research data

All the responses provided will be kept strictly confidential and will be anonymised. The data collected will only be used for evaluative purposes, and individual participants will not be identifiable in any reports.

Ethical approval

Ethical approval has been granted by the School of Medicine Research Ethics Committee (reference number: DClinREC 21-004) and HM Prison & Probation Service (reference number: 2022-017).

Who is the researcher?

The lead researcher is a Psychologist in Clinical Training at the University of Leeds:

Consent to take part

I confirm that I have read and understood the above information explaining the evaluation project and I have had the opportunity to ask questions about the project.

I understand that my participation is voluntary and that I am free to withdraw by closing the survey window down. This is up until the point where I have finished the survey and my responses have been submitted.

I understand that my answers to the questions on this survey will be anonymous and that no identifiable information will be collected.

I understand the findings of this survey will be made available to me.

Please indicate whether you provide your consent to take part in the study in order to proceed to the questions. ✱ *Required*

- ○ Yes, I consent to taking part in this survey
- ○ No, I do not provide consent to take part in this survey

Next >

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An Evaluation of Joint Case Working on the OPD Pathway

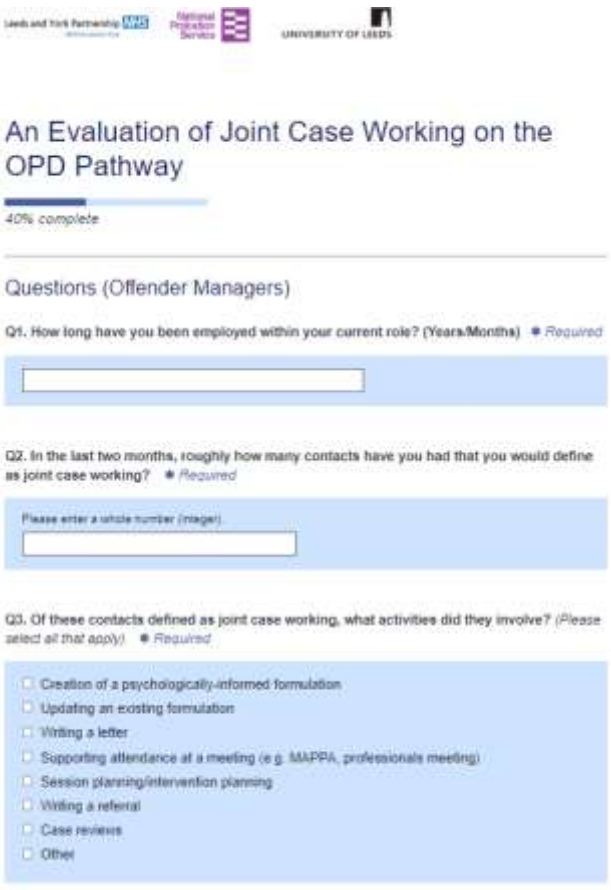
20% complete

Questions - Job Role

Please indicate your job role: * *Required*

- ○ Offender Manager
- ○ Clinician

‹ Previous | Next ›



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An Evaluation of Joint Case Working on the OPD Pathway

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Questions (Offender Managers)

Q1. How long have you been employed within your current role? (Years/Months) * *Required*

Q2. In the last two months, roughly how many contacts have you had that you would define as joint case working? * *Required*

Please enter a whole number (integer)

Q3. Of these contacts defined as joint case working, what activities did they involve? *(Please select all that apply)* * *Required*

- ☐ Creation of a psychologically-informed formulation
- ☐ Updating an existing formulation
- ☐ Writing a letter
- ☐ Supporting attendance at a meeting (e.g. MAPPA, professionals meeting)
- ☐ Session planning/intervention planning
- ☐ Writing a referral
- ☐ Case reviews
- ☐ Other

This part of the survey uses a table of questions. view as separate questions instead?

Q4. Please consider the following statements and rate your agreement of each. * *Required*

Please don't select more than 1 answer(s) per row

Please select at least 5 answer(s)

	1 = Strongly Disagree	2 = Slightly Disagree	3 = Neither Agree nor Disagree	4 = Slightly Agree	5 = Strongly Agree
I have a clear understanding of what activities or contact(s) are defined as joint case working	☐	☐	☐	☐	☐
Joint case working has had a positive impact on my practice	☐	☐	☐	☐	☐
I have been able to apply skills from joint case working to other areas of my practice	☐	☐	☐	☐	☐
Joint case working is an important part of my work	☐	☐	☐	☐	☐
Joint case working has had a positive impact on risk management	☐	☐	☐	☐	☐

Q5. Have you experienced any of the following as a barrier to your involvement in joint case working? *(Please select all that apply)* * *Required*

- ☐ Lack of time
- ☐ Lack of resources
- ☐ Lack of opportunity for contact with clinician
- ☐ Other

Q6. Do you have any other comments about your experiences of joint case working?
Optional

‹ Previous Finish ✔

An Evaluation of Joint Case Working on the OPD Pathway

60% complete

Questions (Clinicians)

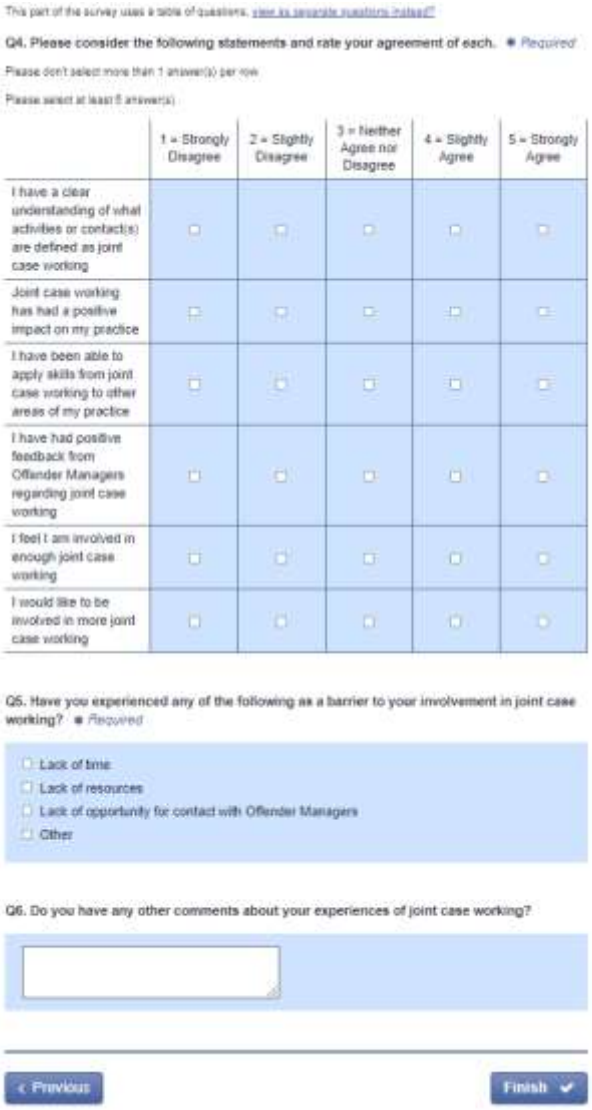
Q1. How long have you been employed within your current role? (Years/Months) * *Required*

Q2. In the last two months, roughly how many contacts have you had that you would define as joint case working? * *Required*

Please enter a whole number (integer)

Q3. Of these contacts defined as joint case working, what activity did they involve? *(Please select all that apply)* * *Required*

- ☐ Creation of a psychologically-informed formulation
- ☐ Updating an existing formulation
- ☐ Writing a letter
- ☐ Supporting attendance at a meeting (e.g. MAPPA, professionals meeting)
- ☐ Session planning/intervention planning
- ☐ Writing a referral
- ☐ Case reviews
- ☐ Other



This part of the survey uses a table of questions, view as separate questions instead?

Q4. Please consider the following statements and rate your agreement of each. * *Required*

Please don't select more than 1 answer(s) per row

Please select at least 5 answer(s)

	1 = Strongly Disagree	2 = Slightly Disagree	3 = Neither Agree nor Disagree	4 = Slightly Agree	5 = Strongly Agree
I have a clear understanding of what activities or contact(s) are defined as joint case working	☐	☐	☐	☐	☐
Joint case working has had a positive impact on my practice	☐	☐	☐	☐	☐
I have been able to apply skills from joint case working to other areas of my practice	☐	☐	☐	☐	☐
I have had positive feedback from Offender Managers regarding joint case working	☐	☐	☐	☐	☐
I feel I am involved in enough joint case working	☐	☐	☐	☐	☐
I would like to be involved in more joint case working	☐	☐	☐	☐	☐

Q5. Have you experienced any of the following as a barrier to your involvement in joint case working? * *Required*

- ☐ Lack of time
- ☐ Lack of resources
- ☐ Lack of opportunity for contact with Offender Managers
- ☐ Other

Q6. Do you have any other comments about your experiences of joint case working?

< Previous | Finish ✔

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An Evaluation of Joint Case Working on the OPD Pathway

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Final page

Thank you for your participation in this evaluation. Your time and responses are greatly appreciated.

Additional interview opportunity

As part of this service evaluation, **we are also seeking to interview Offender Managers and Clinicians about their experiences of joint case working.** Interviews will be via Microsoft Teams at a time and date that is convenient for you, and are anticipated to last approximately 30 minutes.

Appendix B: Interview topic guide

Topic guide for interviews

Sample demographics: Gender/age bracket

Prompts or additional considerations in italics – considering whether clinician or OM is being interviewed will vary.

1. **What is your current job role? (Clinician/Offender Manager)**

- *How long have you been working within this role/service?*

2. **What is your understanding of joint case working within the service? What does joint case working mean to you?**

3. **How much joint case working have you been involved with?**

- *What proportion of your work would you estimate is made up of joint case working?*
- *How much do you perceive the service to be doing? / In line with wider service expectations? Sufficient opportunities?*
- *Types of activities this may have involved …*

4. **Have you found joint case working to impact on…**

- *Risk? Formulation development or revision? Psychological understanding?*
    - *Examples of a time where this has been put into practice?*

5. **Have you found joint case working beneficial?**

- *What aspects in particular?*
- *Example of a time where it has worked well?*
    - *How important you perceive joint case working to be?*

6. **Has anything got in the way of your involvement in joint case working? Barriers…**

- *Can you provide examples?*

Anything else important to know about joint case working.

Appendix C: Recruitment email

Subject: Your views on joint case working – evaluation opportunity

Hello,

You are being invited to participate in a **short survey** that aims to evaluate experiences of joint case working within the offender personality disorder pathway. The survey should take **no longer than 10 minutes** to complete.

Your participation is entirely voluntary; however, we would appreciate your views to help inform recommendations and suggestions for the service going forwards.

For more information on the evaluation and to complete the survey, please follow the link below:

[*survey link pasted here*]

This evaluation is being carried out by *name* (Psychologist in Clinical Training) from the University of Leeds. Please feel free to contact *name* should you have any queries or concerns (*email address inserted here*).

Additional interview opportunity

As part of this service evaluation**, we are also seeking to interview Offender Managers and Clinicians about their experience of joint case working**. Interviews will be via Microsoft Teams at a time and date that is convenient for you and are anticipated to last approximately 30 minutes.

If you are interested in participating in an interview, please contact *name* at *email address inserted here.*

Appendix D: Template summary

Interview no: **Interview date:** **Job role:**	
Domain:	**Important quotes:**
JOB ROLE	
PROPORTION OF JCW	
IMPACT OF JCW	
BENEFITS	
BARRIERS	
ANYTHING ELSE	
OTHER OBSERVATIONS	

Appendix E: Quotation table

Understanding of Joint Case Working		
Theme	**Subtheme**	**Illustrative quotations**
1. Lack of clarity	Fluid definition	▪ I don't know whether things like MAPPA or meetings like that are classed as joint working as well potentially (C1). ▪ It's quite a fluid definition (C2). ▪ You don't say, we'll do some joint case working now (C2). ▪ I don't really think we know what we mean when we say joint case working (C3).
	Purpose of defining	▪ There's a difference in what joint case working means to different parts of the organisation (C3). ▪ What is it when we say joint case working first of all, start from a definition and why do we have that definition, what's the purpose in defining it this way rather than that way? (C3). ▪ It's hard to put it in more tangible terms…but I think that it works and sometimes we don't need to quantify it as long as it's like yes this feels ok (C4).
2. Direct versus indirect	Benefit of meeting/observing	▪ When you actually meet them and kind of you know feel what's going on and the interactions or can observe it or you're in receipt of that it really helps (C1).
	Outsider perspective	▪ I know there's the option, I've still never done it, of meeting with the PoP directly (C2). ▪ The beauty of this job is you get to be very objective because you've not met the person (C2). ▪ I really like coming in fresh to a case and not having as much prior knowledge (C4). ▪ It's been more in the background rather than us having more like joint meetings with the POP (PP3). ▪ Having that information has been better than [clinician] attending. (PP4).
3. Links with consultation	Distinct from consultation	▪ JCW feels very much like you're joining with [the PP] and working alongside them rather than providing more kind of expert advice…it feels more collaborative and shared (C4). ▪ I thought it was a consultation and formulation and then that was it, it's not (PP1).

	Overlap with consultation (recording)	▪ When I first started there was that initial difficulty between shifting from more consultation-formulation led (C1). ▪ I very rarely put joint case working…otherwise I would just put consultation (C2). ▪ For recording purposes, it goes down as consultation or formulation writing/updating (C3).

Impact of Joint Case Working		
Theme	**Subtheme**	**Illustrative quotations**
1. Increased psychological understanding	Theory-practice links	o What are the personality difficulties going on here? I'm not a massive one for labels but it sounds like emotionally unstable PD and they go oh my god that's them (C2). o It is often useful to go back to the theory (C2). o Working out where anger, aggression and a lot of the behaviours were coming from (PP2).
	Shared knowledge and understanding	o It's really enriched that understanding (C1). o People give really good feedback in terms of understanding. It works for things like engagement, developing relationships, helping with trust issues (C3). o It just helps to sort of put a better understanding and explanation on why they have committed the offence and what to look for moving forwards (PP1).
	Risk assessment and management	o He comes across as quite unmotivated or very placid and doesn't give answers and I think that's interpreted as he doesn't understand his risk (C1). o You can lose sight of the fact I don't think risk is an issue here (C2). o If you did a structured professional judgement tool you wouldn't find much. (C2). o If things were going downhill, what this might look like, what to expect (PP1). o If anything significant comes out, it would be noted, especially in the risk assessment (PP2). o It could have gone really pear-shaped and it didn't, I'm wondering if [clinician] helped to contain that and probably stop somebody going back to prison who might never get out (PP4).

2. Impact for PP	Reassurance and validation	○ It's good to know that when you do the formulations that you have done everything you could possibly do and it's really not a reflection on you (PP1). ○ It can sometimes feel as if you're not getting anywhere. You feel as if it's your fault that they're not getting anywhere and they're not progressing (PP3). ○ As a professional, sometimes thinking I shouldn't feel like this but [clinician] will say it's OK to feel like that (PP4). ○ It's that validation that they aren't by themselves (C4).
	Personal wellbeing	○ They're understanding of the pressures that we have on us as well…being asked are you doing alright, how is this affecting you? (PP3). ○ I feel really relaxed and like it's really helped me too, making that time (PP4). ○ Reflection but also reflexivity, thinking about the stuff that they bring as individuals and why they might be struggling with this particular case (C4).
3. Clinician contribution	Who is 'the expert'	○ I don't know how much more I bring (C2). ○ We're here as a resource for probation practitioners (C3). ○ I'm not the expert, it's the offender manager who's the expert (C4). ○ I suppose we do have a fair bit of knowledge around psychology and how it can impact people but we're not professionals like a Psychologist […] it's good to bounce ideas off someone who is obviously very qualified (PP3). ○ I wish I had [clinician] on every one of my cases (PP4).
	'Showing how, doing with'	○ Thinking is essential and that's part of the formulation and understanding and then saying well you could do this and that but showing them how to do it or doing it with them I think a lot of probation staff really like that (C1). ○ I see my role as if I'm helping somebody understand how to better work with their PoP…it's a success if they are able to go away and implement those things in the relationship with the PoP (C3).

Benefits of Joint Case Working		
Theme	**Subtheme**	**Illustrative quotations**
1. Clarity of options	Confirming decisions	○ It feels like when you've got a few different options and you go to the PD team you end up leaving with one definite option (PP1). ○ You'll have like an idea in your head, it could be linked to this or it could be linked to that, and for someone to say I think you're right and take it that step further (PP3).
	Considering alternatives	○ A lot of people who I see, sometimes things just feel very stuck, they've tried lots of different things and they don't know where to go next...I think that even just coming up with some suggestions helps them with feeling a bit more unstuck (C4). ○ I didn't really know that much about Discovery [until JCW meeting] (PP1). ○ You thought I'd never really considered that originally (PP2). ○ [Clinician] would give me new ideas where I felt like I'd come to a bit of an end (PP4).
2. Partnership working	Clinician contact	○ They are always willing to talk to us and help us to understand (PP3). ○ I can't say anything but positives (PP4). ○ There are challenges, understandably different points of views on what people's primary objectives are between healthcare and public protection, but for the most part PPs are really open to the idea (C3).
	MDT working	▪ It opens a lot more doors and gets you in contact with the right people (PP1). ▪ I was trying to get social care to understand how to ask him questions and how to deal with him…[they] were struggling a bit, so [clinician] allowed them to come along to one of our sessions so they could understand and share how to deal with him (PP4). ▪ Multi-agency professionals' meetings…that really helps that joined up understanding, otherwise recommendations and decisions are made in silo and it's really not helpful…joining that all up (C1).

Barriers to Joint Case Working		
Theme	**Subtheme**	**Illustrative quotations**
1. Lack of awareness	Opportunity for exposure to JCW	o I didn't really know joint working was something could be offered (PP1). o Like most things in probation it's about someone going oh this exists do you want to have a go with that (PP2). o I wouldn't say in our training that we get any information about it. I do think it could probably be a bit more well-advertised (PP3). o I don't think everybody knows about it…I joined one as part of training (PP4). o I don't think I've been directive with it and the PP just hasn't taken it up for whatever reason (C2). o I don't think people maybe know so much that there is scope for joint case working as in direct work (C3).
	Dependent on caseload	o You may get quite a lot of support out of the OPD pathway but [the POP] doesn't meet that threshold (PP2). o Sometimes there's some crossover where it's not hugely obvious that person might screen in (PP3).
	Staff turnover	o Changes in staffing, I'd plan a piece of joint working with someone and then they'd go on long term sick or get a promotion or maternity…none of these things you can help or predict and so the work didn't start (C1). o We do regular briefings with probation teams to let them know we are still here, who we are, what we do, so the constant new staff also know we're a resource available to use (C3).
2. Expectations	'Fear of the unknown'	o Especially with newly qualified officers and it's the unknown, what are you going to be asked (PP4). o I'd feel a bit like are they judging me, am I doing my job wrong, and I don't know whether that's how other people must feel (PP4).

	Perception of Psychology	○ We try to show people who are less open to doing consultation with Psychologists what we do, how we do it, and it's not threatening and we give them a little taste of it in various conversations (C3). ○ Why would we expect probation staff to understand our role as a Psychologist, when we say direct work maybe that isn't enough information, they don't know what that means from a Psychology perspective (C3).
3. Motivation	Personal 'buy in'	○ I'm quite interested in that side of probation so I will always utilise the support (PP2). ○ I think it depends how much we as practitioners want that support (PP3). ○ It's coming from a place of I've got to tick a box, I have to do it, rather than from a place of curiosity to understand the person (C4).
	Suitability for JCW	○ They don't know why they're coming, occasionally they haven't met with the POP either (C2). ○ Our job is to consult on the issue brought by the PP not necessarily the whole case (C3). ○ We can only work with what people are bringing and if they don't bring anything it's very difficult to work with (C4).