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Understanding forensic nursing staff attitudes towards men who have committed sexual offences: a narrative intervention

Abstract

Methods: The intervention was delivered through a one-day workshop (n=3) using a narrative informed intervention.

Results: Pre and post measures evidence clinically significant change in the attitudes and perceptions of staff, with change evident in a positive direction. Qualitative analysis demonstrates the thickening of narratives. An increase in person-centred care plans and a decrease in the reliance of restrictive practices to safely manage perceived risks occurred throughout the day.

Conclusion: The results highlight the strength of applied learning tasks centred on care aspects of the forensic nursing role to enhance changes in routine practice and to challenge stereotyped attitudes.

Keywords: attitudes, sexual offender, narrative, intervention

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Introduction

The effects of labelling 'sex offenders'

The label 'sex offender' has assumed a distinctive place in contemporary vocabulary.[1] The label carries its own assumptions and beliefs, which promote and reinforce negative attitudes. Regardless of whether one commits an offence or not, a label such as 'paedophile' holds connotations that one would associate with committing a sexual crime.[2] Surveys of the general public conclude that sex offenders are at high risk of recidivism;[3] despite official figures demonstrating that those who commit sexual offences are one of the lowest recidivist offender populations.[4] Forensic nursing staff have been found to have more positive attitudes that are less stereotyped.[5] However, it should be considered when one's attitude improves in the context of length of time in employment. It is important to support newly appointed staff to begin to challenge their own attitudes. In practice, it would seem that the label of 'sex offender' invites people to react emotively and reinforces pre-conceived attitudes and beliefs about the potential risk presented by this type of offender. It compromises our capacity to make accurate, evidence-based conclusions regarding suitably proportionate risk management. In the context of narrative therapy, [6] this would suggest that we privilege 'thin' narrative descriptions regarding those who commit sexual offences.

An introduction to narrative therapy and the assumptions

Attitudes are largely informed by language and the stories that are told about offender groups and the crimes that they commit. Therefore, a narrative-informed intervention has the potential to support the privilege of thick narratives in treatment settings. This approach encourages the staff team to think critically about the potentially prejudiced and invalidating impact of language, not only for offender management but also for rehabilitation. Other benefits include allowing staff the space and distance to work with the whole aspect of the person in a way they do not perceive as compromising their personal or professional integrity, or feeling forced to choose between the two. Narrative therapy originates from postmodernist theories developed by White and Epston (1990). According to the principles, we make sense of our experiences through narratives that we construct about ourselves and the world around us. They are considered fluid and context dependent[7] and impact upon the way we think, feel and behave in situations (White & Epston, 1990). Some of these narratives potentially serve to prejudice and have unhelpful consequences. The narratives people appear to privilege in relation to MSO are thin and define those who sexually offend in a way that is not found in other offender groups; i.e. "he is a sex offender" as opposed to "he is a person who has committed a sexual offence". A fundamental assumption of narrative therapy is that problems are isolated; the problem is the problem, the person is not the problem.[6]

The overarching aim of narrative interventions is to develop solutions to problems by encouraging the authoring of alternative stories.[8] 'Thin' descriptions lead to thin conclusions and this can have negative effects, such as the disempowerment of people due to a focus on dysfunction or inadequacy. Once a thin narrative takes hold within a staff team, it becomes easy to find evidence to support dominant, problem-focussed narratives and this is difficult to challenge. White (1995) suggests a number of important practices central to narrative therapy. Constructionists' view of reality is subjective; therefore White (1995) recommends the facilitator to subjugate their role as the expert and instead, take on a co-authoring position in collaboration with those engaging in the intervention. Group members should see themselves as separate from the problem and deconstruct labels through discussions. Once this has been achieved, the problem becomes distinct and group members are able to explore ways of re-adopting less problem-focussed positions to privilege thicker narratives. The process of externalising the problem from the group means that people are able to think more freely about 'unique outcomes', which in this instance includes positive experiences and protective factors that the client holds. Naturally, a shift occurs from the dominant 'thin' narrative, to a 'thicker' and better-informed story of the individual and their journey.

Methods

Participants

To recruit to the research intervention, an email was sent to all staff employed on Ward R, a low-secure step down ward predominantly populated by MSO. Staff were invited to self-refer to the group on the basis that they personally experienced difficulties with this client group. Six staff self-referred however staffing limitations on the ward limited the release of participants; three staff were able to attend the intervention on the day. An overview of the participant demographics is presented in Table 1.

Table 1 Overview of participant demographics

	Participant 1	Participant 2	Participant 3
Gender	Female	Male	Female
Age	44	30	28
Parent	Yes	Step-Parent	No
Gender of child(ren)	Female	Male and Female	N/A
Length of time working in secure care	20 years	2.5 years	3 months
Length of time working with men who have sexually offended	11 months	2.5 years	3 months
Job role	Senior Staff Nurse	Healthcare Assistant	Student Nurse
Previous training regarding men who have sexually offended	No	No	No

Pre and post measures

Perceptions of sex offenders scale: The PSO seeks to measure changes in perceptions following education initiatives, rather than specifically measuring attitudes. It is designed as an alternative to the Community Attitudes Towards Sex Offenders (CATSO) questionnaire[10]. The CATSO has been criticised for measuring knowledge-based attributions towards those who commit sexual offences, rather than respondent's affective judgements[9]. The PSO seeks to examine; an understanding of who those who commit sexual offences are and perceptions about how they should be sentenced or managed post-conviction. Six items are reverse-scored and a constant of one is subtracted from each item. Scores range from 0-5 per item on a Likert-type scale, and from 0-100 for the full scale. Higher scores on the PSO are indicative of more punitive perceptions of those who sexually offend. The PSO has excellent internal consistency.[9]

Attitudes towards sex offenders Scale 21 (ATS-21; Hogue, in press): The 21-item ATS is a revalidated version of Hogue's 36-item ATS,[11] which was an adapted version of[12] 'Attitudes towards Prisoners scale' (ATP). The ATS-21 was used within the current research as an alternative to the ATS-36 due to the findings from chapter four. The ATS-21 has improved psychometric properties (Hogue, in press), whilst remaining highly correlated with the original version. The items are responded to on a five-point Likert-type scale (ranging from 1; strong disagree, to 5; strongly agree). Eleven items are reverse-scored and a constant of one is removed from each item; thus the scoring range for the ATS-21 is 0-84. Higher scores indicate more positive attitudes.

Procedure

The intervention was delivered by two psychologists over the course of one day. A PowerPoint presentation was shown detailing the overarching aims for the day, [13] pathway to sexual offending and an overview of narrative intervention. There were also three key practical group exercises mapped onto the theoretical aims. The intervention used a routine clinical nursing activity 'care planning' and exercises to demonstrate practically how staff attitudes inform the healthcare role and the way they work with service users. The intervention comprised of three stages (Table 2). Each stage built on the former with increasing amounts of information being provided regarding the case vignette. At each stage participants were asked to discuss which piece of information was most salient and why. Secondary to this, the group were asked to develop care plans for Mr X and to reflect on how the care plans changed after each new piece of information. After stage one, participants were provided with psycho-education using Finkelhor's Pathway to Offending. The purpose of this information was to encourage the participants to consider the process leading to committing a sexual offence. Next, participants were provided with some brief information about the concept of narrative intervention to help them to understand the sequence that the intervention would follow. Participants were then issued with a letter from Mr X's sister and were encouraged to discuss the ways that thin narratives may perpetuate problems. This included the perspectives of the offender, the staff's work, their relationship with others, and the capacity to provide support to MSO. Participants were then issued with the final piece of information, designed to build their possible thin narratives into thicker, better-informed narratives, which should be privileged within a treatment setting. This included discussions around sharing unique outcomes and to consider alternative explanations as to why people may commit sexual offences. After reading the formulation in stage three, the group were asked to re-author their original care plans and consider whether there had been a shift in their personal thoughts and feelings. Post-intervention measures were re-administered.

Table 2 Stages of intervention

Stage	Materials
One	Initial referral letter outlining Mr X's offence history and diagnosis, requiring admission to a specialist low secure hospital (Appendix M).
Two	Letter from Mr X's sister to provide further information about childhood and upbringing (Appendix N).
Three	Proposed integrated psychological formulation for Mr X following initial psychological assessment and intervention (Appendix O).

Qualitative data

In addition to the pre and post quantitative data gathered, hand-written verbatim notes were kept to record the discussions throughout the intervention. Data were analysed using a thematic-informed phased approach, as outlined by Braun and Clarke.[14] This method was adopted due to its flexibility and accessibility for the researchers. It required the researchers to become familiar with the data gathered

by reading and re-reading a number of times. An inductive approach was used as the researchers were not bound by a pre-existing coding frame. Next, the researchers identified frequently recurring patterns of responses and codes, in addition to data that was considered salient to the research aims. Sub-themes were generated using the common language identified within the narratives, before refining sub-themes into overarching themes that represented the way in which participant's thoughts and feelings appeared to have changed over time. Finally, themes were compared against the original data to ensure they accurately represented the views of the participants.

Ethical considerations

Due to the sensitivity of the research topic, ethical aspects were an important consideration to protect and reassure participants. Prior to self-referring, staffs were given information to confirm that their anonymity and confidentiality would be maintained throughout the research and within the write-up. At the beginning of the intervention, participants were informed of their right to withdraw at any time and were told that any information previously gathered would be destroyed. Participants were only identifiable through a personal identification number. All relevant material for the research was kept in a locked drawer in line with the charity's Information Governance policy. Participants were provided with ade-brief by facilitators at the end of the intervention and were provided with contact details for both facilitators. Alternatively, participants had the option to self-refer to the charity's counselling psychologist.

Results

Quantitative data

Quantitative data were analysed to determine whether results were clinically significant using the Reliable Change Index (RCI); a measure of significance based on the reliability of the tool. RCI is calculated using the following formula:

$$RCI = \frac{x^2 - x^1}{\sqrt{2(S1\sqrt{1-rxx})^2}}$$

Where x^1 represents the participant's pre score, x^2 represents post score, s^1 represents the standard deviation and r_{xx} is the test-retest reliability of the tool. RCI scores provide a measure of change, the direction of that change and whether the change is reliable. An RCI of $\geq$1.96 indicates clinically significant change[15] beyond what would be expected by chance.

Perceptions of sex offenders scale (PSO)

Table 3 provides an overview of the pre and post scores obtained for each participant on the PSO, along with the RCI. Higher scores on the PSO indicate more punitive perceptions of the case studies; therefore a negative RCI indicates positive change.

Table 3 PSO results

	Pre	Post	RCI
Participant 1	47	29	-11.18
Participant 2	41	33	-6.47
Participant 3	32	21	-7.48

All participants indicate a clinically significant change in their attitudinal scores, indicating a positive attitudinal change.

Attitudes towards sex offenders scale 21 (ATS-21)

Table 4 provides an overview of the pre and post scores obtained for each participant on the ATS-21, along with the RCI. Higher scores on the ATS-21 are indicative of more positive attitudes, therefore a positive RCI indicates positive change. All participants' results indicate a clinically significant change in attitudinal scores from the ATS-21, suggesting that the intervention was successful in promoting more positive attitudes towards MSO.

Table 4 ATS-21 Results

	Pre	Post	RCI
Participant 1	29	50	9.72
Participant 2	58	69	22.97
Participant 3	45	53	23.39

Qualitative data

Data were analysed independently by each facilitator using a thematic-informed analysis[14] described in a previous section. An overview of the themes is provided in Table 5. Each stage will be discussed in turn, considering the themes at each stage.

Table 5 Overview of Themes

Stage of Intervention	Name of Themes
Stage One – Referral Letter	Theme 1 – 'Us'
	Theme 2 – 'Us' vs. 'Them'
	Theme 3 – Family
	Theme 4 – Risk Averse Care Planning
Stage Two – Letter from Sister	Theme 5- 'Them' moved to 'Him'
	Theme 6 – Responsibility
	Theme 7 – Positive Risk Care Plans
Stage Three – Integrative Formulation	Theme 8 – Trauma Informed Care Planning
	Theme 9 – Enabling / Re-Parenting

Stage One – Referral Letter

It becomes clear from the initial thematic analysis that during stage one, perceptions were centred on the negative thoughts and feelings towards the offender.

Theme 1 – 'Us'

Participants voiced negative perceptions relating to their role as a staff member after reading Mr X's referral letter. They struggled to see the service user as a person and just saw their offences; evidencing difficulties in putting aside the label; a common theme found in previous research.[1] Thoughts regarding the referral included *"it's just another sex offender"; "I didn't train for this";* or *"why can't he stay in prison"*. In terms of personal feelings, participants felt *"nervous"* because of the unknown; there were feelings of repulsion, fright and fear, sickness and feelings of *"contamination"*. One participant worried about what working with this client group said about them;

"what does this say about me? What do other people think about what I do?"

Theme 2 – 'Us' vs. 'Them'

Negative perceptions continued when participants began to think about the offender as a person. It focussed on the divide between staff and offender, enhanced by the use of language including; *"monster"* and *"predator"*. Characteristics associated with the offender group were *"manipulative"* and *"untrustworthy"*. Negative beliefs were also held regarding the offender's admission to hospital as an alternative to prison. Participants felt that having a diagnosis was a *"passport"* for a hospital admission. This was predicted to have a negative impact on the ward dynamics as a result of the *"chronic and diverse"* offending behaviours described in Mr X's referral letter.

Theme 3 – Family

Considerations were also given to the family within discussions. This included questions being posed such as *"why haven't his family disowned him?", "has he learnt this behaviour from other family members?"* and *"has he been victimised by his own family?"* There was clearly evidence of suspicion towards the family and thoughts regarding their role in the offending. On the other hand, participants *"feel sorry"* for the parents and assumed they would experience *"shame"* and *"disappointment"*.

Theme 4 – Restrictive care plans

In terms of the initial care plan constructed by participants in preparation for admission of Mr X, this was restrictive and risk focussed. Initially, participants stated Mr X should not be admitted due to his perceived heightened risk level. Participants' placed Mr X on enhanced 15 minute observations to ensure the perceived risk he poses to staff and peers could be adequately managed. In addition, participants limited any access to the internet due to fears he may contact his victims. They highlighted that telephone contact should also be monitored by staff to prevent any victim contact. Finally, participants felt that Mr X *"should never be let back out into the community"*. From the analysis of discussions held after the presentation of Mr X's referral letter, it becomes noticeable that participants held a problem-focussed perception of Mr X, and had significant difficulties seeing beyond his label of a 'sexual offender'. Care plans were heavily risk focussed and there was a general reluctance to consider any positive or protective factors relating to Mr X.

Stage Two – Sister's letter

Following the presentation of the letter received from Mr X's sister, a shift was observed from focusing on personal thoughts and feelings, to considering Mr X beyond his label, with more positive additions to his original care plan.

Theme 5 – 'them' moved to 'Him'

Participants began to consider alternative explanations for Mr X's offending behaviours at this stage of the intervention. Consideration was given to internal factors; *"he has insight and an ability to show remorse, disgust and guilt"* and *"he has difficulties in regulating his emotions which may have impacted on his ability to consider the consequences"*. Discussions were also held around the external factors that may offer explanations; *"he has had adverse childhood experiences"* and *"he may have been searching the internet for images to make sense of his own victimisation"*. Participants discussed the personal qualities that emerged from the letter, including; compassion, consideration, reflexive, humble, problem-solver, a survivor and kind.

There was very little emphasis on personal thoughts and feelings towards Mr X at this stage of the intervention. All participants agreed that they were *"wrong"* about Mr X and began to consider him in a more positive light; therefore 'us' became a redundant theme.

Theme 6 – Responsibility

A shift became apparent from thinking that the family were in some way responsible, to now recognising it was the offender's responsibility. Discussions were held around whether they had let him down by not monitoring him enough. Alternatively, participants felt that the family were very supportive and this acts as a protective factor for Mr X, however emphasis was placed more heavily on his responsibility for his offending.

Theme 7 - Positive risk care plans

The care planning at this stage took a more strength-based approach, looking at the activities Mr X enjoys, his protective factors and how these can be built into his care plan to promote rehabilitation. This included his motivation to engage, his ego dystonic feelings and his supportive family network. In addition, emphasis was placed on not being able to *"change"* Mr X's sexual preference, but to provide him with education around sex and the law to encourage independent risk management. The care plan becomes less risk-focussed, and begins to build in a strength-based approach to his rehabilitation.

Stage three – Integrative formulation

After the final presentation of new information in the form of an integrative formulation, the personal feelings towards Mr X had taken a somewhat softer approach and participants spoke about a need to consider the wider perspective. Feelings included *"sympathy for what he has been through"* as a result of him being *"damaged"*. Participants felt that Mr X required *"TLC"* as a result of his own victimisation.

Theme 8 – Trauma-informed care planning

Again, the care planning took a different approach in the final stage of the intervention, with a much heavier emphasis on skill development and identification of a clear treatment pathway within the context of Mr X's historical trauma. Consideration was given to his relationships; participants felt that avoiding the use of a male care team initially was important, as was the consideration given to the female care team; it was felt that a *"maternal"* approach was important, whilst remaining *"confident, consistent and boundaried"*. In an attempt to overcome the artificial safety in secure settings, participants highlighted the need for positive risk taking, graded Section 17 leave, reduced observations and unescorted family visits. In terms of Mr X's treatment pathway, participants identified the need for skills development, suggesting referrals to group work including assertiveness skills, self-esteem work and integrated trauma informed care. In addition, participants highlighted the need for Mr X to engage in occupational activities in order to develop practical skills and encourage a sense of purpose, consistent with the GLM. In the longer term, participants highlighted the need for Mr X to engage in a SOTP designed to deconstruct his offending and to promote exploration and understanding.

Theme 9 – Enabling/re-parenting

Finally, participants were invited to consider the role they play in working with MSO. There was a feeling that *"we need to instil hope and filter this down to the service users"* and *"see the person, not just the crime or the label"*. Participants also highlighted the need to look at the bigger picture and give their commitment to rehabilitation using a more positive approach. Participants were keen to be perceived as *"enablers"* to rehabilitation, rather than *"disablers"* and to take on a 're-parenting' role.

Discussion

The case study aims to provide an evaluation of the effectiveness of using a narrative intervention with staff who works with MSO and self-identify difficulties in working with such a client group. A measure of RCI provides encouraging results that indicate positive change in attitudes based on clinical significance. The phenomenological change is stronger than the statistical change; it evidences that people go through a process of change in attitudes and this lays the foundation for more thoughtful and person-focussed care and treatment.

Within the qualitative analysis, it was clear from the beginning that participants were taking a problem-focussed stance on care planning and in the sharing of their personal thoughts and feelings, likely to have been informed by cultural myths. Thin narratives were privileged and often used derogatory language such as *"predator"* and *"monster"* to describe Mr X. However, throughout the course of the intervention, narratives became increasingly informed by the sources provided at each stage. This encouraged participants to identify that they needed to see the bigger picture concerning MSO. Within this, participants began to consider alternative explanations for MSO, including internal factors such as poor emotional regulation and external factors such as adverse childhood experiences, which impact on future behaviour and relationships. Participants reported feeling less distressed personally as they shifted their focus from the *"bad bits"*.

Narrative interventions

One of the limitations considered prior to using a narrative informed intervention was the lack of research evidence for utilising narrative interventions in this type of forum. Typically, narrative interventions are used either with children and their families[16] or on an individual basis[17]. The benefits of using a narrative intervention were carefully considered within the design stages and it was felt to be an appropriate use of the therapy model. It allowed staff to explore their own beliefs in a safe manner that locates belief formation within a cultural and societal context. The approach encouraged a more enabling stance and appeared to successfully encourage openness and honesty for participants to share how they truly felt. Taking a less structured approach to a full-day workshop left me feeling nervous about timing and questioning whether the content would fill the time as a result of being dependent on contributions from participants; it was difficult to predict initially how open participants would be. However, due to the self-referral process, participants were motivated, willing and honest throughout the day. This meant that the intervention lasted a sufficient amount of time to effect positive change, as evidenced in the pre and post assessment measures.

Unintended consequences

A potential unintended consequence of this type of intervention is the potential for differences in approaches to care between staff that have and have not engaged. The results have shown positive changes in approaches to working with MSO which may become inconsistent between staff. Those who have not engaged in the narrative intervention may continue with a heavily risk-focussed approach, whilst those who have may be more inclined to take positive risks. Not only could this result in inconsistent management approaches, it could also have the potential for MSO to see opportunities to split teams.

Reliable change index

Using the RCI as an alternative to statistical analysis was deemed appropriate in this case due to the small sample size and the need to measure individual, rather than group change. According to Zahra & Hedge (2010), the RCI excels in conditions of very small samples in comparison to typical non-parametric statistical options, which are more difficult to implement on small sample sizes. One critique of using the RCI is the potential for practice effects to occur when measures are repeatedly administered. However, this was not believed to be an issue within the current case study. In such cases, the RCI formula can be corrected if a control group is used to estimate practice effects[18]

Strengths and limitations

There are limitations to consider when delivering such an intervention that requires an open and honest forum. In order to maintain ethical principles, an intervention of this type requires participants to self-refer based on their own acknowledgment of their difficulties in working with MSO. Although the original invitation email was sent to twenty-seven staff, only six responded to the email, despite professional observations on the ward indicating that many more staff struggle in their work with this client group. This suggests that some staff were reluctant to refer themselves to an intervention which requires such a level of openness and honesty. It requires staff to acknowledge and accept that they find their work difficult, which is not an easy admission for many of us. It may also be difficult for staff to challenge their personal views in order to maintain professional integrity. However, it is hoped that positive feedback from the current participants may increase future numbers in staff based interventions. Furthermore, although this intervention evidences that some staff are willing to acknowledge their difficulties and attend an intervention to challenge this, it is not always feasible to assume that staff can be released from wards. In the current climate within healthcare settings, financial budgets are reducing and staffing levels are influenced by this in a way that means it is difficult for managers to release staff from the wards. This is highlighted by a number of failed attempts to deliver the intervention prior to the day that it was delivered. As the results demonstrate, attitudes shifted from negative attitudes to positive attitudes. It may have been that the information provided at each stage influenced this too much and results may have been more reflective of participant's true feelings if the information at each stage had incorporated both negative and positive attributes. It may be unrealistic to assume that participant's attitudes had completed shifted to entirely positive following the one-day workshop and therefore the information provided may have biased results somewhat.

In addition, the researchers acknowledge the limitations of using Finkelhor's[13] dated model to explain the cycle of sexual offending. The model does not provide an adequate explanation for all types of sexual offence perpetrators and therefore alternative explanations may have been more suitable. However, Finkelhor's model provides a simplistic explanation that can be easily understood by all, thus it was utilised in this instance.

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The main strength of the intervention was the open forum for exploration of thoughts, feelings and attitudes towards MSO. Control and leadership was passed over to the participants, allowing them to direct the intervention to meet their own needs as participants engaging in a targeted intervention. Participants have commented on the effectiveness on a personal level, but also with respect to their ability to work with this client group. In the longer term, the positive effects gained from the intervention serve to improve the implementation of least restrictive care and enhance person-centred working. The intervention evidences the value in taking a narrative approach to working with staff to understand their attitudes and perceptions towards MSO, rather than delivering traditional training, which has been found to have little effect in increasing positive attitudes.[19]

The intervention has one major limitation that would require revisions if it were to be delivered again. As the researcher designed, delivered and evaluated the workshop, there is potential for researcher bias to have been present. This has an impact on the validity of the intervention. To overcome this in the future, it would be beneficial to have different people completing each stage of the case study. In addition, a more reliable qualitative analysis may have been possible if the researcher had audio recorded the entire day. Testing participants on the post-intervention measures on the same day as the intervention may serve as another limitation for the case study. This lack of follow-up does not allow for staff to return to their duties to determine how effective the intervention has had on their clinical practice. If a follow-up period had been utilised, the post-intervention results may have differed from those presented. Follow-up periods should be utilised where possible to enable effective evaluation of intervention upon clinical practice.

Clinical implications

The intervention highlights the importance of encouraging staff to acknowledge and challenge their own attitudes and perceptions towards MSO. From a professional practice perspective, it is hoped that interventions of this kind may help to limit the use of restrictive practices informed by a service user's index offence and prevent the use of punitive practice. MSO require a positive and collaborative treatment approach that is person-centred, holistic and least restrictive. However, as highlighted in the initial stages of the intervention, this may be compromised by the attitudes held by some members of staff. The study evidences the efficacy of implementing an intervention to challenge 'thin', punitive narratives and the restrictive practice that can flow from such narratives. Furthermore, the study highlights the potential for new narratives to emerge along with more person-centred practice. From a care planning perspective, the intervention evidences the positive impact that increased knowledge and alternative perspectives can have on care plans. During the intervention, there was a shift from restrictive, heavily risk-focussed care plans, to person-centred; skills-based care plans that evidenced a clear treatment pathway. Initially, there was a feeling within the room that Mr X should *"never be let out"* and this was reflected in the heavily restrictive initial care plan. However, the final care plan began to consider discharge planning and the therapeutic treatment requirements for the service user to engage in. The final care plan considered existing strengths and ways in which these could be built upon, as well as equipping Mr X with new skills. This evidences the importance of working with staff to explore the way they perceive MSO to place less emphasis on unreliable subjective feelings, but to triangulate their 'gut' feelings with more objective data (e.g. Offence Paralleling Behaviours) to provide a more systematic approach. For MSO themselves, it is hoped that the outcomes from the intervention with staff filters down to instil increased feelings of self-worth as a result of the increased positivity in those who support them. By taking a skills-based, discharge planning approach to treatment pathways and care planning, this may instil hope for each of the men and encourage them to think about discharge from the point of admission. The importance of hope in forensic patients has been highlighted within the literature[20] and emphasises hope as being a primary goal in line with the GLM.[21]

Conclusion

Narrative-informed group intervention has been found to be successful in equipping staff with the information to develop well-informed attitudes and perceptions towards MSO. The current intervention highlights the importance of such interventions to improve professional practice and consider the wider implications of negative or punitive attitudes. The intervention is a successful alternative to traditional training methods and provides significant support for use in forensic services.

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Conflict of interest

The author declares there is no conflict of interest.

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