THE STATE HOSPITAL BOARD FOR SCOTLAND

PSYCHOLOGICAL SERVICES

ANNUAL REPORT

January 2021- December 2021

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1 Core Purpose of Service/Committee

The State Hospital provides high-quality care and treatment for people with highly complex mental health needs, high risk for violence, and support to embark on their recovery journeys. Psychological therapies come to the fore in these journey's when helping patients reduce their risk of offending by addressing needs linked to criminality. However, psychological therapies work in conjunction with pharmacological treatments to reduce symptoms of mental disorder (also associated with risk) and increase the likelihood of recovery journey's taking place. Psychological interventions are resource-intensive in a high secure setting due to the long term and intense nature of the therapies. For example, there may be 3-4 staff involved in group therapies in delivering one programme. Treatments are offered one to one or via evidence-based group programmes. Risk assessment and risk-based formulations led by PTS services allow clinicians to develop plans for implementing individualised PTS therapies. Highly trained and experienced practitioners within TSH deliver group treatment sessions up to several times per week. Some intensive group programmes take over a year and a half to deliver (e.g., Life Minus Violence). One to one therapy is provided based on the following model: Cognitive Behavioural Therapies for Psychosis, Mentalisation Based Therapy, or Cognitive Analytic Therapy are long term interventions with gradual change being observed clinically. Risk assessments using Risk Management Authority accredited approaches for general violence, sexual offending, stalking, partner violence, combined with scenario planning and risk management within TSH, dovetails with PTS therapies using formulation. The formulation is a means of helping patients understand how they came to be in TSH to increase understanding of how problems developed from childhood to the current time and what maintains distress and risks.

Outcomes for PTS in High Security across the UK are challenging to demonstrate. Recent research has shown that it is challenging to conduct randomised control trials. The most recent evidence for PTS therapies in high secure shows a lack of positive outcomes and poor-quality studies.[1] This is also the case for other bedrock treatments in high secure (anti-psychotic medication).[2] This is a serious challenge to all high secure services. Whilst there are extensive local outcome measures for groups and one to one therapy, this does not scientifically prove positive outcomes and does not allow comparison within different types of therapies or between treatments. There are two streams of work underway to address this (international) problem, including:

- UK heads of Psychology in High Secure Services developing UK position statement on standard pre-post measures used for each therapy and to review the measures used in each hospital developing common themes which are measured then develop guidelines on a peer review framework for pre and post measures. This would allow the potential for large scale evaluations across four UK high secure PTS services.
- The future of psychological therapies in forensic mental health services in Scotland.
- UK wide coordination on robust 'single case design' outcome publications.

However, it should be borne in mind that 60% of therapy outcomes are based on "non-specific factors' (therapeutic engagement, communication, shared decision making, high-

[1] Gilling McIntosh, L., Janes, S., O'Rourke, S., and Thomson, L. D. G. (2021). Effectiveness of psychological and psychosocial interventions for forensic mental health inpatients: a meta-analysis. Aggress. Violent Behav. 58:101551.

[2] Howner K, Andiné P, Engberg G, Ekström EH, Lindström E, Nilsson M, Radovic S, Hultcrantz M. Pharmacological Treatment in Forensic Psychiatry-A Systematic Review. Front Psychiatry. 2020 Jan 16;10:963.

quality formulation, embedding therapies in broader ward/hospital context); hence there is an increasing emphasis in the literature to focus on process or quality measures. TSH PTS service has had a strong track record year to year, presenting significant quantities of quality assurance information.

With these caveats in mind, The Local Delivery Plan (KPI) targets for the psychological therapies are:

- 80% attendance by clinical psychologists at annual and intermediate reviews.
- 100% attendance by Psychological Therapies representative at annual and intermediate reviews.
- 85% of patients will be engaged in psychological treatment
- 100% of patients will have their clinical risk assessment reviewed annually
- 100% of patients will commence psychological therapies in less than 18 weeks from the referral date (this target is designed by the Scottish Government for community psychological therapy services).

The KPI targets are underpinned by several supporting measures, including:

- Monitoring of Clinical Outcomes in Routine Evaluation (CORE-OM), scores for psychological therapies
- Monitoring the proportion of patients with a psychological formulation
- Provision of reports in advance of annual review meetings
- Attendance at clinical supervision

Group interventions are monitored, and pre-post psychometrics, as well as clinical outcomes, are included in patients reports.

The ongoing Covid-19 pandemic has led to extreme challenges for psychological therapies, particularly group therapies, which are the mainstay of our psychological interventions. Special Leave (self-isolation) and sickness levels are higher than usual correlated with activity reductions. In addition, psychologists and nurse therapy staff in PTS are being asked to relocate activities to ward setting. Like other NHS staff, psychological therapies staff found these parameters challenging but creatively ensured interventions continued to a high standard.

Finally, it is often the case that data does not capture the transformation that can occur due to psychological interventions in our patients lives. To capture ‘lived experience’ patient outcomes and psychological therapy roles, a selection of case vignettes are included in this report.

Case Vignette 1 by Dr Natalie Bordon, Clinical Psychologist

Throughout the pandemic there have been many challenges faced in the delivery of psychological therapy for our patient group. From distancing to face mask wearing, both staff and patients have adapted to ensure that these vital therapies continue to be delivered to facilitate not only support to patients but so that they can continue with their pre-pandemic care and treatment plans. Perhaps one of the greatest challenges was the delivery of psychological therapy groups. While these interventions can be adapted to be delivered individually, by doing so, patients miss out on the peer-assisted learning and continued development of social skills such as turn taking and working together. With the household 'bubble' model in place, in Lewis hub we sought to devise a way of facilitating small therapy groups to enable the above mentioned benefits whilst also adhering to infection control guidance. By having an oversight of the 3 wards on the hub and collating patients' care and treatment plans, we were able to group patients together to allow groups to be facilitated based on patients' needs. We then liaised with both RMO's and nursing staff to help look at upcoming patient moves and worked together to ensure patients with similar treatment needs were 'bubbled' together.

We ran four different small groups from our low intensity suite of psychological therapies and based each of them within Lewis Hub. Logistically these groups were supported through joint working between the psychology team, nursing and AHP to allow sessions to continue as planned despite some disruption due to covid. Feedback from patients was particularly positive in that they felt small groups made up of peers from their own wards allowed them to feel more comfortable in familiar surroundings with familiar staff and peers. This appeared to be particularly important given patients were functioning only within small groups for a significant period of time, therefore this allowed patients to gradually become more comfortable in a larger group setting. Patients voiced that they enjoyed the group interaction and ability to listen to peers' experiences and offer their views and support. Indeed, patients stated that this group cohesion and dynamic continued within the ward, with them often discussing the concepts or homework tasks together out with sessions. Additionally, staff noted that these patients began to form relationships out with the group setting, often seen walking together in the grounds and offering social support to each other.

We believe that this example highlights that group psychological therapy is not only a resource effective way of delivering therapy but that it also teaches patients more than protocol content. By being together in the room, patients are able to improve their social skills, be given opportunities to display their theory of mind and empathy towards others and also become "experts by experience" as they guide and support their peers. Observationally, not only did patients improve their understanding of mental illness and their repertoire of coping skills, they felt included and listened to by having their opinions and experiences validated by not only their therapist but also their peers. Given that a large proportion of our patient group have had difficult attachment styles and experiences, these groups are vital for repairing some of these earlier negative relational experiences.

2 Current Resource Commitment

The budget for PTS services is in appendix one. There are no financial issues for the service. The staff group compliment currently is as follows:

PTS services have had a high level of stability with staff for many years, but there is a current challenge in 2022 with three long term staff are leaving for promoted posts to the same board, as well as one long term member of staff retiring in 2022.

Table One: Psychology Service in 2021

Job Title	Actual WTE	Budget WTE	Comments
Specialist Nurse Practitioner	3.0	3.0	
Advanced Nurse Practitioner	2.0	4.0	2 vacancies
Nurse Consultant	0	0.5	
Assistant Psychologist	3.5	4.5	1 vacancy
Trainee Clinical Psychologist	3.0	3.0	
Trainee Health Psychologist	1.0	1.0	
Clinical Psychologist	2.6	4.0	Vacancies plus reduced hours
Principal Psychologist	1.0	1.0	
Consultant Forensic Clinical Psychologist	2.70	3.0	reduced hrs
Head of Psychological Services	1.0	1.0	
Total	21.8	25.0	
Total minus trainees and assistants	15.3		

The current headcount for psychology therapy services is:

1 Head of Psychology
3 Consultant Forensic Clinical Psychologists (leads)
1 Consultant Neuropsychologist
3* Clinical Psychologists
4 Nurse Therapists
3 assistant psychologists
3 Trainee Clinical Psychologists
= 12 staff (not counting unqualified assistants and trainees)

We have recently appointed two nurse therapists who commenced employment in September 2021 and a Consultant Nurse Therapist who commences April 2022. There was a significant lead in time for new staff before seeing patients.

*One Clinical Psychologist could not see patients for a considerable period for health reasons during 2021.

In summary there was a qualified head count of 11 staff over 2021 who were able to see patients. The service is now fully recruited.

3 Summary of Core Activity for the last 12 months

PTS work extends well beyond patient therapies, and staff well-being is no exception. Dr A Cooper, Clinical Psychologist and Dr Pat Cawthorne, Consultant Nurse. Their final updated staff well survey report was completed in December 2021. The service is extensively involved in publishing ground-breaking research – these details are available in research updates.

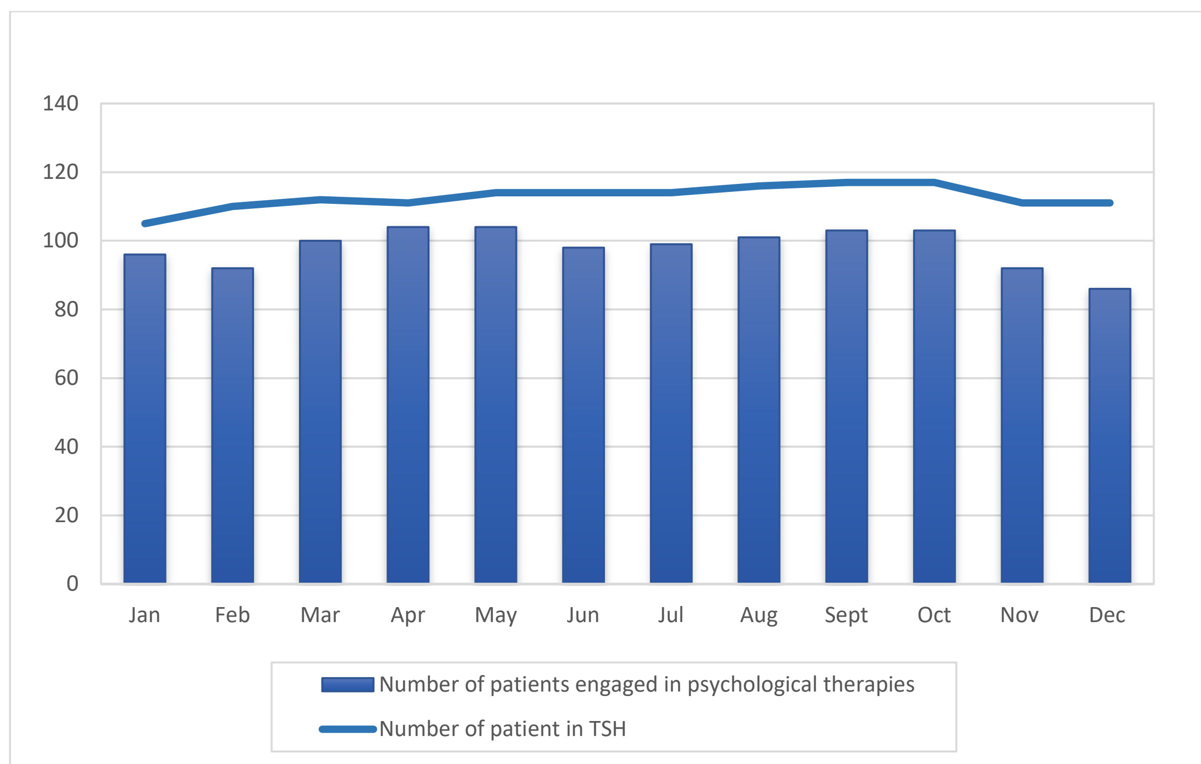
Case Vignette Two by Dr Jacqueline Geddes

A primary presenting difficulty for much of our population is the absence of secure attachment relationships. It is a fundamental role of Clinical Psychology to support patients to develop secure attachments within the hospital setting. Often this can initially begin with their designated therapist and can be the cornerstone for all other treatment. This is challenging work that demands a therapist to provide a consistent and secure base whereby a patient can feel safe enough to express their emotions and be supported to regulate and contain these. The past 2 years have presented The State Hospital with monumental challenges and have threatened our ability, as therapists, to be present for our patient population.

As I reflect on this time, I recall a significant period whereby one ward was isolated for a number of weeks due to a Covid-19 outbreak. One of my patients found this profoundly challenging due to his usual ability to have access to services being disrupted. Although telecommunication was facilitated, this did not provide the level of support necessary to contain this patient's distress. I therefore worked with the clinical team and organisation to provide my patient with his therapy sessions in person. This involved using appropriate measures (i.e., masks, sanitiser, ventilation, distance) but was without question the necessary action to support my patient to manage an exceptionally challenging time for him.

I am in no doubt this patient's progress would have been significantly disrupted had myself and the team around him not worked together to ensure his in person contact could be supported in a time we were being actively encouraged to stay apart. As we have progressed through this pandemic, this patient has gone on to being able to branch out in his ability to develop secure attachments with others and has begun the Life Minus Violence Programme. I am exceptionally proud of his progress.

The following Chart One below reports on the number of patients engaged in psychological interventions from January 2021 to Dec 2021. On average, 87% of patients were engaged in a psychological intervention at any one time over the year. This compares to 86% in 2020 and 87% in 2019Chart One: Number of patients engaged in psychological interventions from January 2021 to December 2021.



For the first time in the State Hospital PTS annual report history, we were provided with benchmark levels of engagement in other high secure services enabling comparisons in engagement levels for psychological therapy across UK High Security in 2021. Engagement in Psychological Therapies is defined for all high secure services as one-to-one therapy or group therapy. This is the beginning of a benchmarking process that will evolve in future. See Table below.

	High Secure Hospital 1	High Secure Hospital 2	High Secure Hospital 3	State Hospital
% Patients engaged in Psychological Therapy	87%	76%	98%	87%

Group work interventions were adversely impacted this year. Table Two below highlights group work intervention data:

Table Two: Number of patients On the Road to Recovery Modules:

Year	Awareness & Recovery	Looking After Yourself	Total
2012	25	22	47
2013	26	28	54
2014	27	20	47
2015	6	8	14
2016	12	15	27
2017	13	6	19
2018	12	18	30
2019	13	8	21
2020	6	6	12*
2021	24	26	50*
Total	**164**	**157**	**321**

*Due to Covid-19 restrictions, these sessions had to be completed on a 1:1 basis to ensure that patients were not adversely impacted. This took up significant resources when multiple patients can attend one group normally. New groups were delayed due to the need for developing digital solutions for group work, but one to one session continued for patients. PTS services have traditionally supported staff on the wards on an ad hoc basis or carried a responder and responded to incidents. PTS have increasingly been asked to support ward nurse staffing deficits. This figure is anticipated to rise over the coming months for the reporting period 2022-23. PTS will track adverse impacts on core PTS assessment and therapies business.

Chart Two below highlights the number of sessions per month and the hours spent covering the wards.

Chart 2: The number of sessions and time spent covering wards per month.

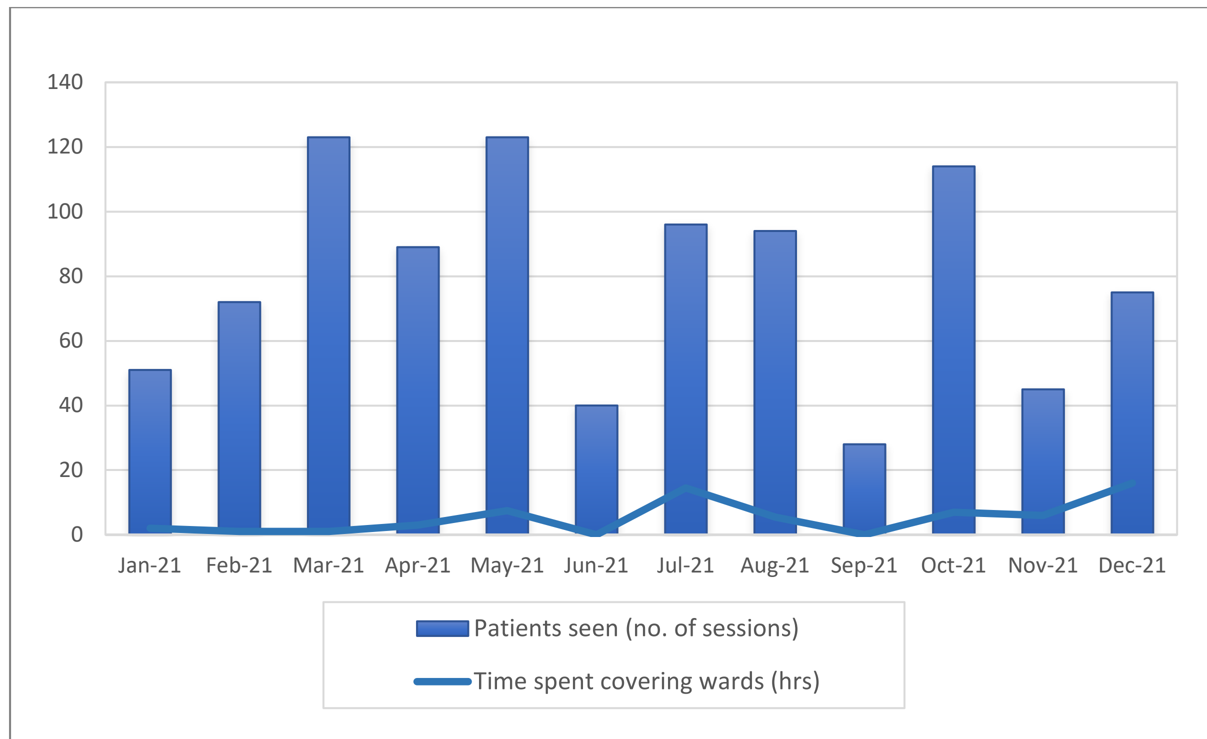


Table Three below highlights activity levels last year.

Table 3: Annual Activity Levels- Clinical Sessions: Group and Individual Interventions						
	2016 (yr)	**2017 (yr)**	**2018 (yr)**	**2019 (yr)**	**2020(yr)**	**2021 (yr)**
No. of individual sessions	4129	3695	3088	3410	1154	1275
No. of group sessions	183	214	200	218	102	142
No. of Ward Talking Groups	441	351	340	324	139	162
Total clinical sessions	4753	4260	3628	3952	1395	1579

Psychological service activity has not returned to pre-covid levels with significant impacts in group therapies. Group therapy referrals (see below) are reduced and as measures reduce PTS will communicate to clinical team and the RMO that group work is fully restarting. PTS services are determined to return to normal levels of therapy delivery, notwithstanding any future restrictions. PTS remains proud of the unique breadth of group therapies delivered in TSH compared to other forensic services.

There has been a reduction of one-to-one therapy figures this year. There are a number of reasons for this. Based on figures for special leave or absence, STSS data showed that in 2019 over 200 hundred hours were lost in absence such as sickness and in 2021 over 566 hours were lost due to sickness, household isolating, positive Covid-10 test and childcare issues. Moreover, there was a long-term sickness absence matter, a psychologist who could not have patient contact for a significant period, two nurse therapy vacancies, a consultant nurse vacancy, all of which increased the challenges to activity levels for therapies. In a review of PTS staff feedback for this report on one-to-one figures the above reasons were provided along with challenges related to wards closures and patients isolating having some impact on individual contacts. There was a recent additional issue with patient's normal routine being impacted on due to bubbles etc, this has resulted in patients being unavailable, at times, for arranged appointments. This matter has been raised at the Patient Timetable meeting. Furthermore, data feedback on one to one's has been variable the previous year, and the actual one to one figure is likely to be higher. Significant new measures have been implemented to capture full activity data including month to month reviews and targeting of specific teams, in situ data gathering by administration at the end of each monthly hub team meeting has commenced. We anticipate significant improvement in the coming year. Bench marking work is under way to highlight expected levels of activity in the service compared to other high secure services.

Table 4: Groups ongoing or commenced in the last year.

Group	Commenced	Ended	No of patients	Current status
LI - Knowing Me			0	
Complex Needs - Life Minus Violence Modules	9/05/19	27/09/21	12	New group commenced 9/12/21 with 6 patients and 1 one to one
Complex Needs - Mentalization Based Therapy (MBT)	26/10/21		4	ongoing
Healthy Living Group	4/02/20		0	On hold, pending
MBTi			0	
Planning for the future			0	
On the Road to Recovery - Awareness & Recovery	Jan 2021	Dec 2021	Approx. 24	Completed on a 1:1 basis due to no cross hubbing of patients
On the Road to Recovery - Looking after Yourself	Jan 2021	Dec 2021	Approx. 26	Completed on 1:1 basis due to no cross hubbing of patients
On the Road to Recovery - Making Healthy Changes	6/10/20 20/07/21	27/01/21 24/11/21	6 8	completed
Self-Awareness - Tune In			1	One to one

Self-Awareness - Skills for Relating Well			0	
Self-Awareness – Relating Well			0	

Case Vignette three from Dr Louise Kennedy, Consultant Clinical Psychologist

Between May – August 2021 family therapy sessions were facilitated in the Family Centre in conjunction with the Person-Centred Improvement team. The sessions focused on helping a patient and his family members repair relationships and move forward. Conducting these sessions in the Family Centre allowed a safe, quiet, and private space where the patient and his family could address issues relating to risk and mental health. The patient and his family were able to have conversations facilitated by his psychologist which had been avoided for some time but which both parties felt were important in terms of moving their relationship forward. Having the support of the Patient Centred Improvement Team allowed the consideration of the facilitation of sessions to be paced in a manner appropriate to the family and as the team already had good relationship with the family allowed further support for the family if needed. By the end of our sessions the family felt that they had a better understanding of each other's perspectives and had been able to be open and honest about their concerns and hopes. They were looking to the future together as a family and felt more able to address issues as they arise. The ability to assist in repairing attachment ruptures or disruptions is critical to future well-being and acts a protective factor to reduce risk for violence.

Table 5: New referrals to interventions between January 2021 – December 2021

Intensity of Intervention	Therapy	Total 2019	Total 2020	Total 2021
Complex Needs – Specialist	CBT for Psychosis	3	1	
Complex Needs – Specialist	Life Minus Violence	2		1
Complex Needs – Specialist	Neuropsychology Assessment or Rehabilitation			
Complex Needs – Specialist	Sex Offending Treatment (SOT)		2	
Complex Needs – Specialist	MBT	1		1
Complex Needs – Specialist	MBTi	3		
Physical Health Interventions – Healthy Living Group	Healthy Living Group	2	6	
On the Road to Recovery-Low Intensity	Awareness & Recovery	16	15	13
On the Road to Recovery-Low Intensity	Looking After Yourself	19	15	10
On the Road to Recovery-Low Intensity	Making Healthy Changes	10	9	2
Low Intensity Looking to the Future	Knowing Me Planning for the Future	1 13		
Self-awareness & Management – high intensity	Tune In	1		1
Self-awareness & Management – high intensity	Relating Well	8		4
Self-awareness & Management – high intensity	Skills for Relating Well	7		4
TOTAL NO. OF REFERRALS RECEIVED		**86**	**48**	**36**

Highly Specialist Interventions. Hub psychology teams delivering one to one highly specialist individual pieces of work*.	**115**	**89**	**97**

Risk Assessments

Structured risk Assessment is a comprehensive examination, structured reporting, and evidence trail, of likely risk for violence. The Risk assessment process leads to a MDT formulation led by the psychologist and also scenario plans or worst case scenarios and their likelihood as well as likely scenarios. This in turn allows the MDT to risk manage and target risk factors to reduce violence risk. In 2021 89% of Risk Assessments were completed and 90% of scenario plans were completed. The other 11% of risk and 10% scenario plans are ongoing.

Outcomes

The PTS service evaluates all group therapies routinely with pre and post psychometric with key measures of change. The outcome data is limited due to the impact of Covid-19 measure adversely impacting on group therapies. We apply a range of measures such as the CORE-OM. The CORE-OM (Clinical Outcomes in Routine Evaluation – Outcome Measure) is a tool provide designed for evaluation of change in psychological therapies. The CORE-OM has 34 items, all with the same five level response choice, the time frame is the last seven days. It was designed, and this was led partly by the commissioning specification, to cover four main domains: wellbeing, problems, functioning and risk. We have a critical research project ongoing evaluating the utility of the CORE-OM, for example anecdotally we have found that there can be increases in measured distress as group therapies progress and out the hypothesis being tested currently is whether this is due to increasing insight in psychosis as well as violence risk, or the emotional impact of having committed violent crimes. The following is an evaluation of a cohort of 15 patients who completed the Life Minus Violence Programme (or LMV). LMV is an intensive CBT programme to reduce risk for violence. The report compares outcome on the CORE-OM for this cohort to a violence/aggression risk reduction measure.

CORE-OM	Mean	SD	Statistical significance.
Pre	0.72	0.52	
Post	0.53	0.48	NS

Pre and post measures were assessed using the Buss-Perry Aggression Questionnaire (AQ) predicts violence and aggression. This measure has been to predict violence and aggression. Patients respond (prior to the intervention) often by agreeing to statements such as: given enough provocation I will hit someone; If I have to resort to violence I will; I fly off the handle for no reason".

Violence/aggression measure	Mean	SD	Statistical significance.
Pre	27.9	21.56	
Post	17.5	14.21	YES*

* p-value is .00124. The result is significant at $p < .05$ using paired T-test.

There was a significant reduction on a validated measure of violence and aggression following completion of the Life Minus Violence Programme. For each patient (see graph below) there is a considerable improvement demonstrating PTS is addressing criminogenic violence risk.

Other group data outcomes is currently being analysed for the 6 monthly report.

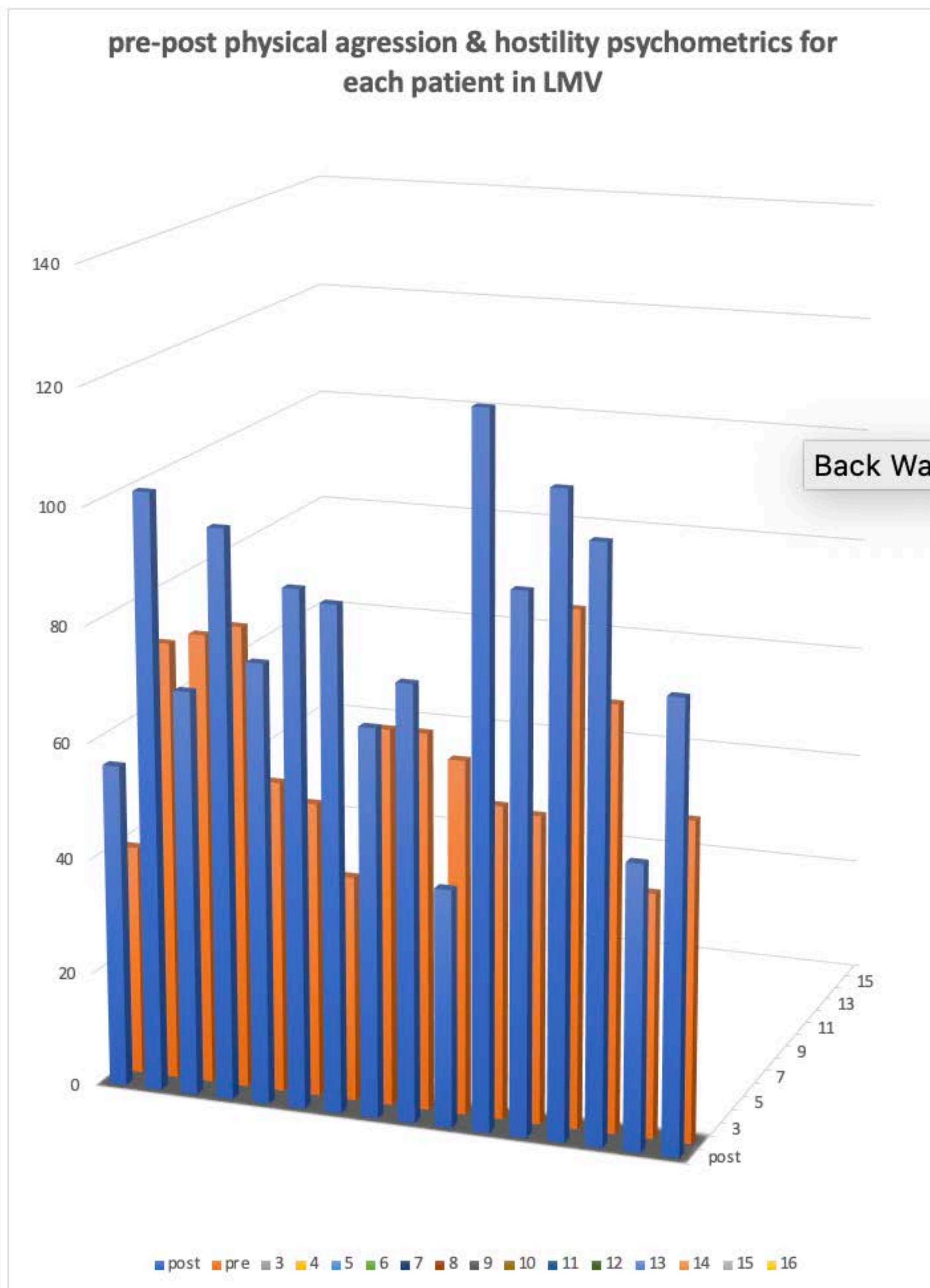
Outcomes can also be measured qualitatively. In a support group therapy delivered in the Lewis hub patients were asked to reflect on the group experience with the following comment examples:

Patient 1 enjoyed learning from others and sharing his own experiences with others in the group. He discussed his long-term goals of being substance free, having people not judge him when he moves on and the prospect of getting a job and purpose in the future for when he moves on. He also talked about how it could be a good idea for group participants to come up with a short story, something creative to write detailing success stories and progress, and this could be shown to future participants of the making healthy changes group for when they start.

Patient 2 commented that he had found the group to be largely positive and that it had given him lots of things to put in his toolkit for moving on. He stated that he found it very useful to hear from other people's perspective and sharing each other's stories for the duration of this group.

Patient 3 did provide some feedback on how he felt the group had gone, and this was largely positive. He stated that sharing about each other's perspectives and experiences was helpful.

As groups return to full capacity we will increase the level of data analysis and begin to plan new work on comparing interventions across the high secure services


pre-post physical agression & hostility psychometrics for each patient in LMV
140
120
100
80
60
40
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0
Back Wall
15
13
11
9
7
5
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post
post pre 3 4 5 6 7 8 9 10 11 12 13 14 15 16

In terms of VAT data, Covid-19 presented challenges described in Table Six below.

Please note the VAT completion data. The completion rate should be 90% in order for the data to be robust. However, only one intervention met this rate. The annual 2020 report, VAT completion was on average: Admission CPA (96%), Annual & Intermediate (95%), and Discharge (91%). In contrast, VAT completion in 2021 decreased: Admission CPA (85.3%), Annual & Intermediate (81%), and Discharge (63%). Thus, the biggest issue for 2021 has been VAT form completion.

Admission CPA					
	VAT completion	**Number of Reviews**	**Number Done**	**% Done**	**Comments**
Psychologist discussed the content of report with patient	**82.4%**	34	26	76.50%	A 25.5% improvement from 2020
Psychology Admission Report available at Admission Case Review	**82.4%**	34	22	64.70%	A 0.2% improvement from 2020
Psychologist attends Admission Case Review	**91.2%**	34	27	79.40%	A 19.4% improvement from 2020
Annual and Intermediate Reviews					
Psychologist discussed content of report with patient - annual review only	**76.1%**	88	55	62.50%	an 8.5% decrease from 2020
Psychology report available at Case Review - annual only	**84.0%**	88	71	80.70%	a 5.3% decrease from 2020
Psychologist attends	**82.0%**	194	128	66.00%	a 2.5% decrease from 2020
Any Psychological Therapies staff attending	**82.0%**	194	156	80.60%	a 1.4% decrease from 2020
Discharge					
Discharge Charge Report available	**65.2%**	23	10	43.50%	a 5.6 % increase from 2020
Psychologist attends Discharge CPA	**60.9%**	23	10	43.50%	a 6.5% decrease from 2020

*From January-March 2021, this information was collected from the Day of Discharge VAT which is completed by the medical secretary when they are collating the documentation to be forwarded with the patient on discharge. From April 2020, the Discharge Psychology Report is required at the patient Discharge CPA meeting.

(*Note Action on VAT issue* – several PTS and PTS leads meetings have taken place to discuss this matter to assist PTS to come up with their own solutions. At the last meeting of every hub PTS meeting, it was decided that admin and staff will complete VAT and routine activity data at the end of every monthly meeting in situ). It is anticipated that this will increase adherence levels.

4 Comparison with Last Year's Planned QA/QI Activity

In the last report, the PTS Team worked with NHS QI on QI improvement methodology then reviewed to develop more efficient sequencing of group therapies. This project has been adversely impacted by the pandemic but will continue. A further QI project from the previous report was to improve the quality and consistency of assessment and formulation by using an audit methodology. This is ongoing.

5 Performance against Key Performance Indicators

Compared to the KPI:

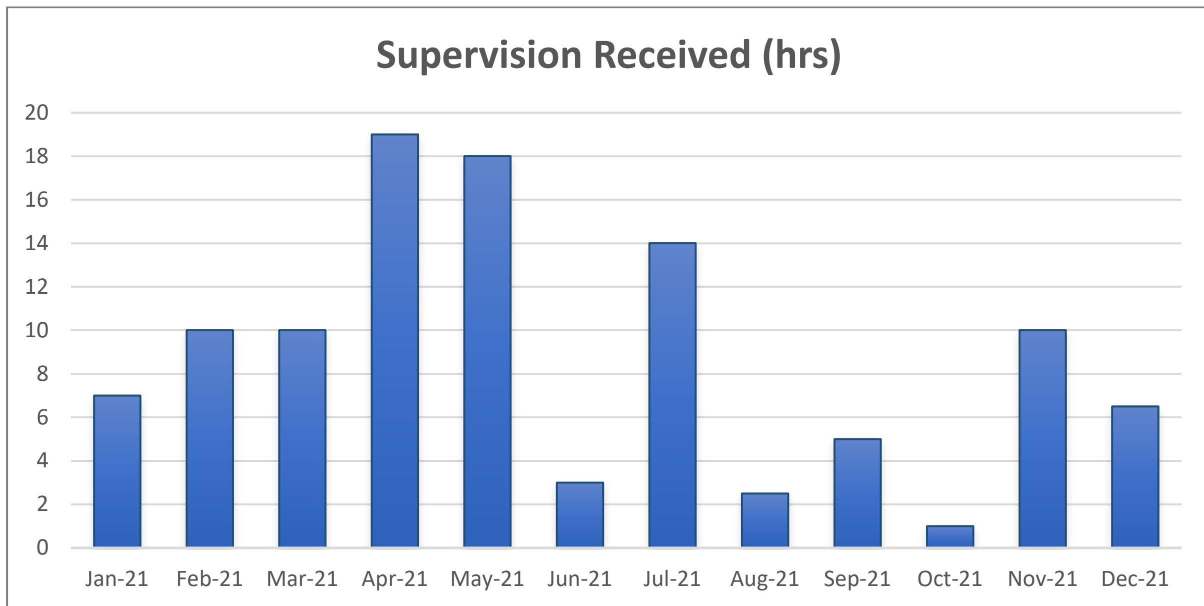
- 80% attendance by clinical psychologists at annual and intermediate reviews. This was lower but VAT attendance completion rates are not high enough to provide accurate figures.
- 100% attendance by Psychological Therapies representative at annual and intermediate reviews. This figure was 80%
- 85% of patients will be engaged in psychological treatment. This Target was met with 87% engaged in therapies.

100% of patients will commence psychological therapies in less than 18 weeks from referral date (this target is designed by the Scottish Government for community psychological therapy services). This target is intended for community psychology services. PTS is proud to not have a waiting list for interventions

6 Quality Assurance Activity

The following assurance activities occur Monitoring of VAT figures; all patients have a clinical formulation that is being audited against a formulation exemplar and analysed for a report due April 2022 (led by Dr Burnett). Outcome measures in therapies and group therapies are administered. Clinical Supervision is an essential part of quality assurance and service delivery. Hours for PTS spent in supervision are as follows:

Chart Three: Hours in supervision per month for PTS staff.



Stage Based Trauma Intervention via a Pandemic Vignette – Dr Kerry Jo Smith Clinical Psychologist

Mr M was the victim of prolonged childhood abuse and neglect which he found highly traumatic. When I took over as ward Psychologist in 2018 I recognised that despite numerous medications and engagement in a range of psychological therapies his responsiveness was limited and he remained very distressed, with little progress in his recovery. I formulated that Mr M's psychological functioning was undermined by complex post-traumatic stress disorder and that a stage-based trauma intervention was an unmet treatment need. It had previously been felt that that Mr M would be unable to manage the intensity of the required intervention.

Over the next two years, significant progress was made via the safety and stabilisation stage of therapy. It took the consistency of the whole team being trauma responsive in all of their interactions with Mr M alongside twice weekly therapy. Trauma processing is highly intensive and can destabilise prior to further improvements. Carrying out any type of trauma processing therapy within the State Hospital is in itself challenging due to the environment itself.

Unfortunately, as trauma processing commenced, the Covid-19 pandemic disrupted hospital functioning. However, to have commenced this stage of therapy and left it open would likely have been more detrimental to the patient. Narrative exposure therapy (NET) provided the means for Mr M to organise his memories whilst also drawing out his strengths which he often over-looked in his self-story focussed on trauma. Although trauma processing was indeed challenging for Mr M, with periods of increased distress, as therapy progressed, he seemed to reach a stage wherein we saw the efforts of the safety and stabilisation stage begin to be of benefit. He began for the first time to make regular, active use of healthy ways of responding to his distress. He began to recognise that these methods were often effective for him and steadily gained more confidence in his ability to self-manage.

This was an intensive and challenging period of therapy for Mr M which spanned three and a half years. With support from the Psychologist and wider team Mr M overcame significant additional challenges the pandemic brought to therapy. Trauma responsive care by the whole team was integral to the success of this therapy as was the team's trust in the Psychologist and the chosen therapeutic model. Now that therapy is complete, Mr M's psychological functioning is more stable than has ever been known for him. His symptoms of PTSD have reduced and when they do occur are mostly self-managed, with significant reduction in use of PRN evidenced. He has a full placement timetable and is now actively engaging in further therapy with a hope to move forward from the State Hospital following completion. At the outset of therapy in 2018, Mr M was unable to leave the ward due to chronic distress. To see him now functioning at such a high level and to see him without distress much of the time, is truly the most rewarding aspect of my role. I will always be proud that I led a team who were brave enough to do the hard work with this patient. Scary, challenging therapy that our environment does not host comfortably, that requires guts and trust in each other throughout the ups and downs of patient recovery. It is what we are here for, the effort is what our patients deserve, and it is so worth it.

7 Quality Improvement Activity

Teleconference equipment was tested during pandemic restrictions to deliver video linked groups. The equipment was deemed not fit for purpose due to the impossibility to share critical resources or screen share, and also be able to observe reactions and interactions closely as one can do on a screen-based platform like Teams.

A Digital Health Steering group was formed looking specifically at providing virtual groups-based interventions and digital platforms whilst considering information governance challenges. The local group is awaiting national guidance from the Scottish Government on the platform 'Near Me' then will consider its application to TSH. PTS is fully engaged in seeking a usable group therapy platform in future given the unpredictable nature of the global pandemic. We need to be ready to switch to digital based group therapies if need be in future.

Further investment in Life Minus Violence (LMV) training with two additional staff fully trained in 2021, underlining the PTS commitment to intensive high 'dosage' group therapies. Staff training in house has taken place on Foetal Alcohol Spectrum. Monthly professional and research meetings to share best practise were reinstated in 2021.

A training programme to Skye Centre staff commenced focusing on motivational to change unhealthylifestyles and increase motivation to make healthy living changes. This training was very positively reveived by staff. Further training to the Skye Centre staff was cancelled at the end of the year however will be completed in February 2022

8 Stakeholder Experience

Every year group therapies satisfaction levels have been very high for patients, but there was insufficient data for groups in 2021. In one-to-one clinical sessions, psychologists seek constant feedback in sessions and adjust the interventions based on the patients' experience. Clinical formulations are not 'given to' patients but co-constructed by patients and psychologists. These are developed and tweaked at the MDT team level.

9 Planned Quality Assurance/Quality Improvement for the next year

Table 7: The following Action plan update is based upon the previous 6 monthly report in 2021 with additional plan updates.

Consider low intensity training in psychological trauma for nursing staff	In progress	National trauma framework online training promoted to all staff. Discussions underway regarding feasibility of training and implementation of Completed PTSD group programme (highly complex level intervention).
Outcome measures comparisons to other services	In progress	Outcome measure research Sept 2022 Psychological Therapies Short-Life Working Group underway to report on Scotland wide outcomes (no time scale agreed as yet)

		National UK leads producing paper on conducting outcome research in high security October 2022
Efficient Sequencing of Groups	Restarted	This has restarted January 2021, report on QI project August 2022
Deliver Healthy Living Group in Each hub	In Progress	Affected by pandemic now recommenced.
Clinical Formulation	In Progress	Report on June 2022
Pilot of new Matrix Consensus Cognitive Test Battery (MCCB)	Ongoing	Delayed by pandemic due to need for testing materials and close work with patients. This work has commenced, and report completed August 2022
Neurodevelopmental pathway	Ongoing	Training and formulation training completed.
Develop state hospital module in collaboration with national sex offender treatment planning programme	Ongoing	J Marshall and Joe Judge working with staff from national programme which was paused during pandemic.
Health Psychologist	In Progress	-Monies located for post and agreed, post matched -Description completed, liaison with Dr V Swanson, NES on the first post of its kind in the UK Advertised by end of February 2022
MAP, NES, health psychology motivation training to increase positive health behaviours and increase to two health psychology trainees to focus on health and obesity reduction agenda	Dr Louise Kennedy/ Dr John Marshall	NES trainee health psychologist in place to support delivery.
Trauma-Informed Care containing two elements (1) TSH staff training on NES Trauma-informed care and (2) Complex Trauma Therapeutic Group work pilot	Dr Amelia Cooper Dr John Marshall	Support and training from NES ongoing
Sexual Harm Service To develop and implement Moving	Dr John Marshall	National strategy planning replaces Moving forward making changes. Current challenges as that SPS developing SPS only national programme.

Forward Making Changes (MFMC) adaptation for people experiencing psychosis from national developments on MFMC		

10 Next review date

The review date will be January 2023.