Psychological Therapy Services Annual Report Jan 2024- Dec 2024

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1. Core Purpose of Psychological Services.

Psychological services within the State Hospital have a multifaceted role. This includes delivering services to patients as well as working systemically to support the Hospital to be more psychologically, trauma and risk informed. Within forensic services risk assessment and management is a fundamental element of a patient's care and treatment. It should underpin all other therapeutic work. Within the State Hospital, Psychological practitioners are responsible for the completion of appropriate structured clinical judgement risk assessments and subsequent risk management plans as well as for reviewing these, with contributions from clinical teams, on at least an annual basis. The team are also responsible for delivering risk training to the hospital workforce.

Psychological services also provide evidence based psychological assessments and interventions to patients within The State Hospital with the aim of reducing the risk that a patient is considered to present as well as improving the patients understanding of their risk, reducing psychological distress and enhancing insight and coping skills. Psychological practitioners are involved with patients throughout their recovery journey. A patient's therapeutic journey starts during their psychology admission assessment and risk assessment, the outcome of which involves generating a psychological formulation to be discussed with the wider clinical team regarding the patients underlying psychological mechanisms which contributed to and maintain their difficulties. This will identify areas for psychological intervention and risk management. Each patient has a named clinical psychologist who is responsible for their overall psychological care and treatment and who ensures that their psychological needs are being met. The psychology service has a wide skill set of psychological practitioners who deliver psychological interventions to patients. A range of psychological interventions in both group and individual format are available which address underlying needs related to offending, risk and poor mental health. Psychological services are responsible for planning, coordinating and delivering both group and individual therapeutic interventions and ensuring that these are delivered in a safe and timely manner and in line with evidence base and best practice guidelines including the National Psychology Specification[1] and The Psychological Therapies Matrix[2]. Psychological interventions are resource-intensive in a high secure setting due to the long term and intensive nature of the therapies being delivered. Highly trained and experienced psychological practitioners deliver group treatments, with some intensive group programmes taking over 18 months to deliver (e.g., Life Minus Violence, MBT). Individual therapy is specifically aimed at addressing the unique underlying psychological needs relevant to individuals and their offending. Psychological practitioners are trained in a wide range of psychological models and approaches.

Service development, training, research and contributing to the Board's wider strategic objectives are also core elements of the Services' workload.

2. Psychological Services Staffing Resource as at 31.12.24

Job Title (Head count: 25)	Actual WTE.	Budget WTE	Comments
Specialist Nurse practitioner (2)	2.0	3.0	
Advanced Nurse practitioner (2)	2.0	4.0	2 vacancies
Consultant Nurse (1)	0.5	0.25	
Assistant Psychologist (4)	3.0	4.0	
Trainee Clinical Psychologists (3)	3.0	3.0	Funded by NES
Clinical Psychologists (5)	4.0 (3 in post)	4.0	
Principal Clinical Psychologist (1)	1.0	1.0	
Health Psychologist (1)	0.8	0.8	
Consultant Clinical Psychologist (4)	3.2	3.0	One PT consultant currently working an additional day to cover mat leave.
Consultant Neuropsychologist (1)	0.2	0.2	
Head of Psychology (1)	0.9	1.0	Seconded for one session to the FN

[1] /www.gov.scot/publications/psychological-therapies-interventions-specification/
[2] //www.nes.scot.nhs.uk/our-work/matrix-a-guide-to-delivering-evidence-based-psychological-therapies-in-scotland/

Over the last annual review period, there have been a number of staffing changes within the Service. We have welcomed two new clinical psychologists to the team; both of them were returnees to the Service. We were able to create a permanent (part-time) Health Psychology post which was appointed to in October. This is a very positive development and one that we hope will enable us to apply for a fully funded NES training position. We were also supported by NES to offer a training place on the Edinburgh doctoral course and are pleased to say that one of our assistant psychologists was successful in obtaining that position; we continue to support three clinical psychology trainees. This is positive for the Service as we have a good track record of retaining those we train when vacancies allow. We have had one longstanding member of the nurse therapy team retire recently and have two psychologists on maternity leave. Unfortunately the link nurse scheme started last January has not continued. The department now regularly contributes to the NES and Public Health Scotland National psychology workforce statistics.

The Clinical model is now well established. This, along with other developments, has indicated that the staffing structure within the service is not correct. We are currently reviewing what staffing each service needs and plan to restructure the service accordingly.

Link Nurses

Four link nurses took up post in January 2024. Each of these secondees was located within the psychology team in each of the four hubs. Link Nurses were to act as a clinical 'link' between the psychology team and the wider multidisciplinary staff and services. The aim of the pilot was to provide a professional development mechanism for nursing staff, enhance communication between services, improve patient care, and increase knowledge transfer between services. Throughout the programme, the Link Nurses played an important role in fostering collaboration between nursing staff, psychologists and other members of the multi-disciplinary team. They facilitated timely exchanges of information about patients and their treatment plans, supporting the coordinated approaches to care. This appeared to improve clinical decision-making and ensured that interventions were tailored to individual patients.

The Link Nurses also took on additional responsibilities, such as providing psychological education to their nursing colleagues, supporting the implementation of psychological interventions, and assisting in the monitoring of patient progress. Key successes of the pilot included enhanced staff engagement, improved inter-professional relationships, providing a 'clinical bridge' between services, enhanced knowledge transfer, and a more holistic approach to patient care. Feedback from both nursing and psychology staff was overwhelmingly positive, with participants noting the programme's contribution to a more cohesive team dynamic as well as enhancing their own skills and knowledge. Findings from a research project investigating the impact of the programme will be published in due course.

Unfortunately it has not been possible to continue the development beyond this year due to over-time costs incurred by nursing as a result of the rostering process.

3. Summary of Core Activity Jan-Dec.

3.1 The table below shows the total number of sessions delivered by psychological therapies staff with years 2019-2023 for comparison. We are very pleased to again report that there has been another increase in clinical sessions delivered over the last year; an increase of 27% in clinical sessions delivered in the past year compared with 2023. This is positive particularly given that the staff team has again been significantly impacted by vacancies and sickness absence. This sees the level of clinical activity to have returned to pre-pandemic levels.

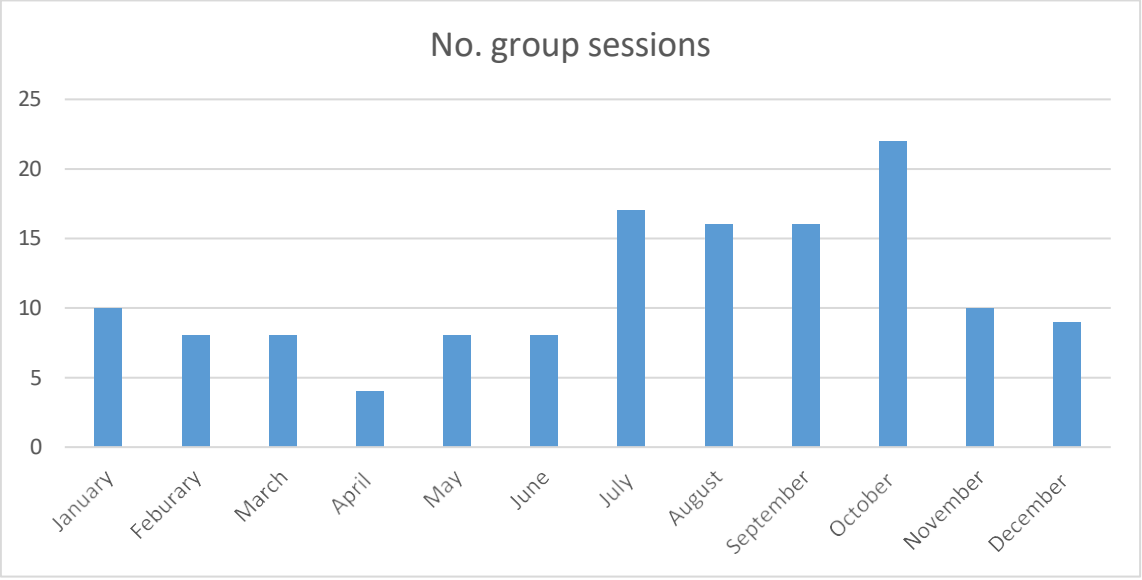
Table 3: Annual Activity Levels- Clinical Sessions Delivered: Group and Individual Interventions

	2019	2020	2021	2022	2023	2024
No. of individual sessions	3410	1154	1275	2119	2676	3770
No. of group sessions	218	102	142	129	156	136
No. of Ward Talking Groups	324	139	162	123	125	237
Total clinical sessions	3952	1395	1579	2371	2957	3743

3.2 Group Therapies in last year.
Over the past year there have been 8 therapeutic groups delivered offering 52 spaces run by the team. This is 1 less than last year. The groups delivered range from Low Intensity Interventions which focus on forming the basic therapeutic skills and understanding which will then enable patients to go on to undertake High Intensity and then Specialist Psychological Interventions which are provided in either a group or individual basis. There has been more resilience in the groups run this year with less cancellations partly due to the link nurses.

In the last year we have identified that improvements could be made in relation to the timeliness of end of group reports. These are essential for updating patient's formulations and risk assessments and need to be accessible to the teams quickly. Responsibility for this will now sit with the Lead Facilitator in the group. In addition we are keen to increase the consistency with which group supervision is held. To support this we have written a new Supervision Policy and will monitor, via the monthly group KPI, whether supervision was planned and attended. The new Psychological Therapies Governance Group will have oversight of this.

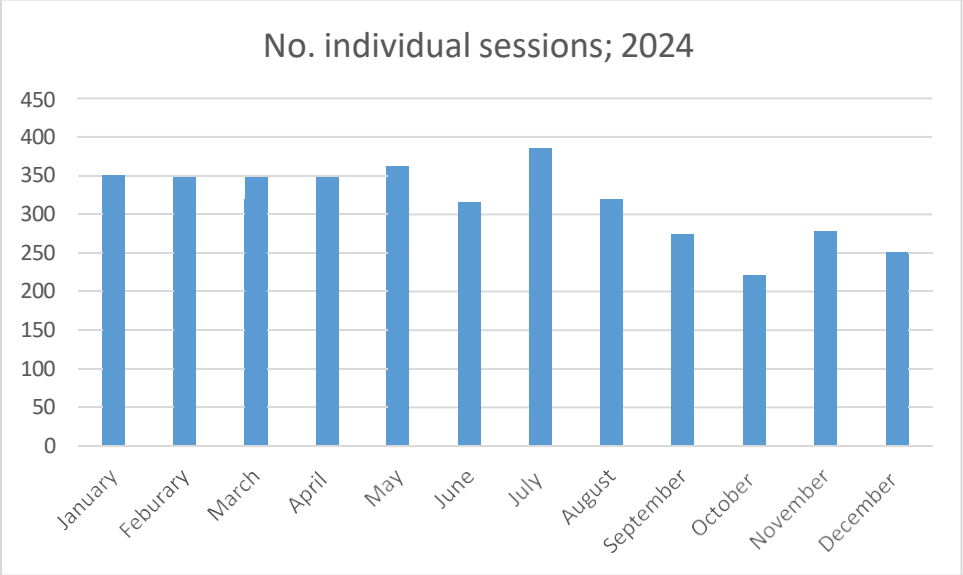
Group	Start date	End date	No. Attendees per group	Supervision sessions required	Supervision Sessions held.
Making Healthy Changes	8/ 23	1/ 24	8	6	0
Looking After Yourself	1/24	3/ 24	8	3	0
Connections	12/ 23	10/24	5	11	3
Making Healthy Changes	6/ 24	10/24	4	5	4
Planning for the Future	7/24	11/24	6	5	1
Awareness and Recovery	5/24	7/24	8	3	2
Looking After Yourself	9/24	2/25	7	4	1
Life Minus Violence	10/24	7/26	6	3	0
Total (8)			52	40	11



3.3 Individual based therapeutic work in last year.

The graph below shows the number of individual sessions delivered over the past year. Individual work can take the format of individual sessions as part of their group therapy programmes, or as one to one psychological interventions addressing separate issues pertaining to mental health or risk. For patients with very complex needs they may receive more than one session of psychological therapy per week with different staff members, however appointments are usually on a weekly basis. Sessions are typically between 30 – 60

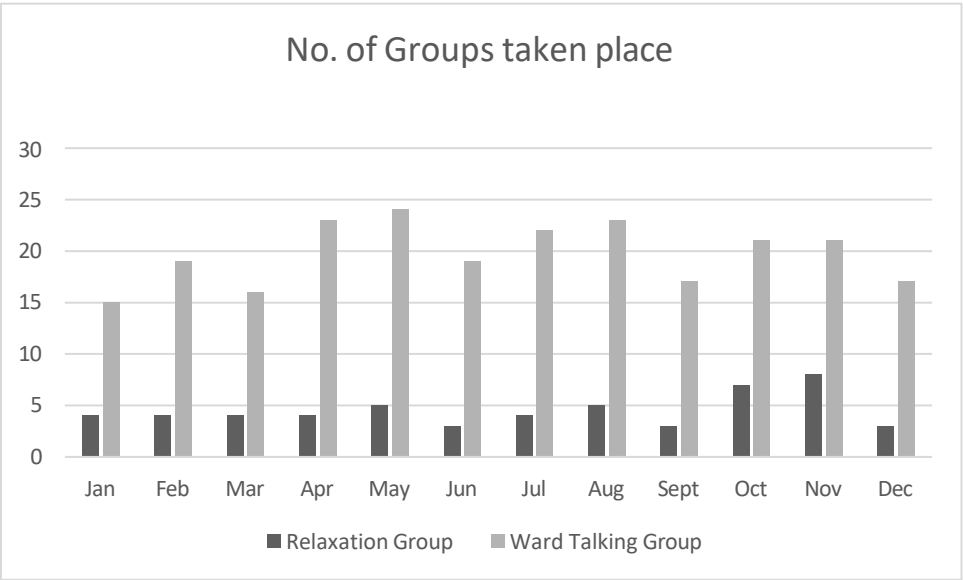
minutes depending on what the individual patient can tolerate. The majority of patients are receiving individual interventions and this has remained constant over the year. There has been a gradual decline in sessions since July which we will continue to monitor.



3.4 Talking Groups and Relaxation Groups over the past year.

The chart below shows the number of ward talking groups and relaxation groups which took place over the last year. Talking groups and relaxation groups are open to all patients and attendance varies each week. Ward talking groups usually require three members of psychology staff to facilitate them. A total of 237 groups have been run this year which is almost double the number run last year. The link nurses are likely to have accounted for this increase. There have however continued to be issues impacting the teams' ability to run these including a lack of qualified staff, high clinical acuity and patients using facility time. The issues having an impact are similar to those identified last year.

There have been 54 relaxation sessions run over the course of the year. In some services these are often facilitated in conjunction with colleagues from the AHP team. These have recently been relaunched in the Transitions service and are also about to re-commence in Lewis.



3.5 Organisational work.

Members of department contribute to many of the organisational service developments and committees, include co-chairing the Mental Health Practice Steering Group and Relational Approaches to Care group. Individuals in the department are also members of various other groups for example the Supporting Healthy

Choices Implementation Group and Child and Adult Protection Forum and they have a lead role in delivering the Trauma Informed Care agenda. Training in risk assessment tools (eg HCR-20) is currently provided twice each year and staff also deliver the mandatory VRAMP training to registered nursing and AHP staff. It has however been identified that this training probably needs to be updated. Psychologists also provide teaching to the Clinical Psychology Doctorate courses at both Edinburgh and Glasgow Universities and regularly deliver training on behalf of the Forensic Network.

One particular area that we are keen to try to progress work on this year is in relation to Digital Interventions and to consider what options there are to deliver psychological therapies locally and nationally via digital means. Members of the team have had discussions with the Scottish Government Digital Lead for Psychological therapies to progress this and the applicability of the use of computerised cognitive behavioural therapy is being explored.

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

Planned Activity	Progress	Update
Recruit to full capacity in order to deliver the work plan.	Ongoing	Vacancy money not required for savings was used to appoint four link nurses and to also fund a temporary increase in consultant and 8a psychology sessions. Some has now been allocated to the Health Psychology post. Skill mix review underway currently.
Increase positive health behaviours. SHC work plan to reduce psychological distress relating to physical health, improve self-management of long-term conditions & weight, and reduce health inequalities within our population	Ongoing	In 2024, the Health Psychologist continued to work in line with the tiered model of care. This included providing direct work with patients with complex needs related to their physical and psychological health. Training has been provided for a range of MDT staff, ranging from a monthly introductory session to 3 days training that supports staff to delivery behaviour change interventions. Tier 1 work has focused on leading the hospitals whole systems approach to healthy weight via the supporting healthy choices programme, which has focused on two key areas: the admission period and the hospital shop.
Trauma-Informed Care containing two elements (1) TSH staff training on NES Trauma-informed care and (2) Complex Trauma Therapeutic Group work pilot (Survive and Thrive)	Ongoing	Training at Level 1 (31 staff) and 2 (49 staff) was delivered throughout 2024 by the Psychology team. Staffing pressures have though impacted this year. Plans are in place to train members of the Nurse Practice Development team to support this training going forward. In addition discussions have been ongoing with the PMVA team with regards to ways in which PMVA can be made more trauma informed. This has commenced with some additions to the PMVA policy. (2)It has not been possible to progress the Survive and Thrive group due to key staff being absent.
NDD Pathway & training plan	Ongoing	The NDD pathway has been agreed and a pilot is being taking forward by the Psychology Lead for the Admission Service.
Sexual Harm Service: To adapt and implement Moving Forward 2 Change (MF2C) programme in the State Hospital.	Ongoing	Roll out of this intervention has commenced in prison and community justice services. TSH staff have been identified and will undertake the training in this programme in June.

5 Performance against Key Performance Indicators

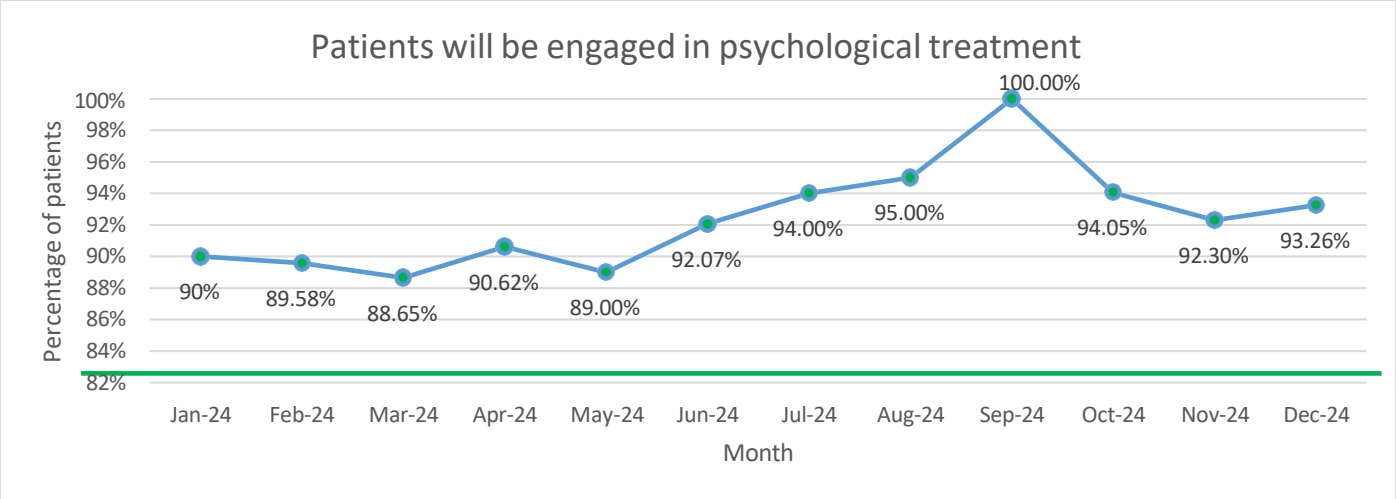
The Local Delivery Plan (LDP) targets for the psychological therapies are:

- **85%** of patients will be engaged in psychological treatment
- **100%** of patients will commence psychological therapies in less than 18 weeks from the referral date.
- **80%** attendance by clinical psychologists at annual and intermediate reviews.

- **100%** attendance by Psychological Therapies representative at annual and intermediate reviews.
- ***100%*** *of patients have their Clinical Risk Assessment Reviewed Annually (Although this is not a Psychology KPI it is considered helpful to report here due to the risk assessments being completed by Psychologists).*

5.1. **Eighty-five percent of patients will be engaged in psychological treatment.**

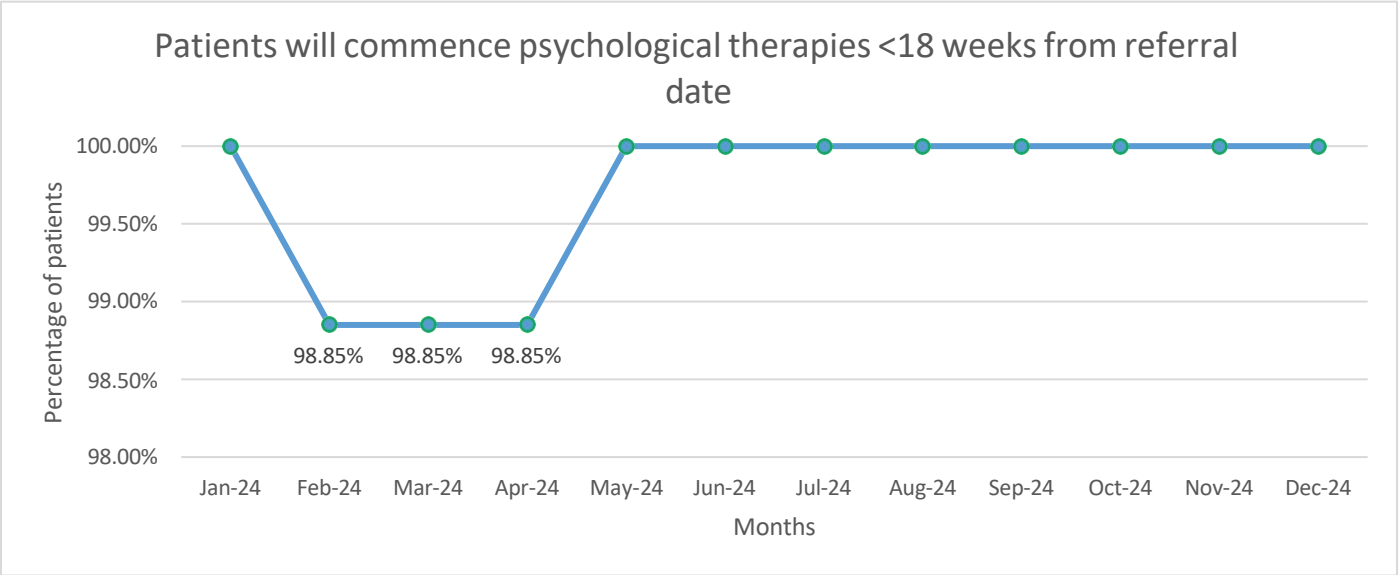
The Chart below shows the percentage of patients engaged in psychological therapy across the year. This shows improvement on the preceding years (in 2022 it ranged between 81 and 82% and in 2023 the figures ranged between 74 and 82%). The KPI reflects that there will be a proportion of patients not engaged in psychological therapy at any one time which can be due to them being unwilling or unable to engage or them perhaps awaiting transfer and having completed all recommended work. The numbers engaged in therapy and the reasons why a patient might not be engaging are monitored by the department. For example, in December although 93% of patients were in therapy at month end, 3 patients had completed therapy that month meaning that overall 96% of patients had been in engage in therapeutic work that month.



5.2. **One hundred percent of patients will commence psychological therapies in less than 18 weeks from the referral date.**

The Psychological Therapies and Interventions Waiting Times Standard Definitions was published by Public Health Scotland (PHS) in September 2023. This document provides guidance for staff delivering psychological therapies and states that 90% of people should start psychological treatment within 18 weeks of referral. Waiting times are calculated based on the time between a referral being received and treatment or intervention commencing. The KPI for the State Hospital is that all patient commence therapy within 18 weeks of referral.

Given the differences around referral for psychological therapy between territorial health boards and The State Hospital, TSH psychology department worked closely with PHS to help them understand the unique way referrals to psychology are made; this would ensure that we were able to record our waiting times in an accurate and comparable way. Within TSH the referral date is accepted as the admission date of the patient to TSH. While patients will be seen by a psychologist shortly after admission for assessment, the standard relates to the commencement of a psychological therapy which would be conducted in line with the National Specification for Psychological Therapies and Interventions and be based on the therapies and interventions described in the Psychological Therapies Matrix. The State Hospital started recording waiting times data from September 2024 in accordance with the Standard. To date all patients admitted to TSH met the 18 weeks target.



However, within TSH patients will be referred for psychological therapy throughout their admission and as such it is important to monitor if any patients are waiting longer than 18 weeks to receive any therapeutic intervention. Data on this will be provided going forward.

5.3. **Eighty per cent attendance at Annual and intermediate reviews**.

Monthly VAT Completion 2024 : We are pleased to report that for the second year running the completion of the VATs has improved. This allows us to better understand issues that may be impacting attendance at CPA meetings.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2024	**91%**	**100%**	**100%**	**100%**	**100%**	**97%**	**100%**	**100%**	**100%**	**100%**	**100%**	**95%**
2023	87%	100%	88%	91%	54%	100%	100%	100%	89%	96%	100%	100%

Attendance at Annual and intermediate reviews.

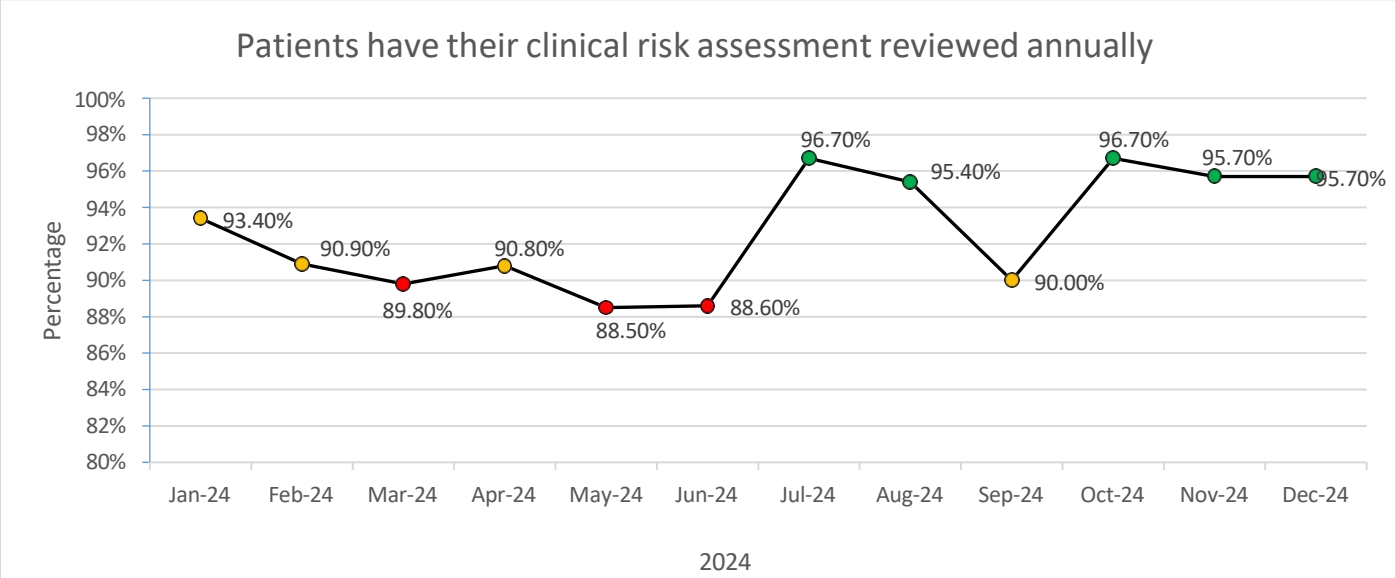
	Jan n=13	Feb n=17	Mar n=16	Apr n=11	May n=16	Jun n=16	Jul n=11	Aug n=13	Sep n=16	Oct n=9	Nov n=20	Dec n=11	KPI target
Psychologist 24 (target 80%)	**92%**	**88%**	**81%**	**91%**	**94%**	**75%**	**82%**	**92%**	**69%**	**100%**	**85%**	**91%**	**80%**
Psychologist 23.	73%	91%	90%	36%	47%	82%	43%	65%	88%	86%	91%	75%	80%
Psy Services 24 (target 100%)	**92%**	**94%**	**94%**	**100%**	**94%**	**88%**	**100%**	**92%**	**88%**	**100%**	**90%**	**91%**	**100%**
Psych Services 23	80%	100%	90%	50%	53%	91%	86%	82%	100%	93%	95%	75%	100%

The team have not only been able to maintain the marked increase in attendance at CPA's seen last year but have made further improvements. We scrutinise reasons for non attendance which have generally been that the CPA has been rearranged at short notice and staff are unable to attend, that they are held on a day that part time staff do not work or that staff who work across services are at another CPA. Given that qualified psychology staffing increased in October and November we confident that we will see further improvements this year also however given the reasons above there may still be potential for occasional CPAs to not be attended. .

5.4 **All patients to have their Clinical Risk Assessment Reviewed Annually**. As indicated above this is not a Psychology KPI however the risk assessments are led by Psychology and it is considered helpful for

the Service to have some oversight of compliance with this KPI. With this greater oversight we have been able to identify some issues with the sign off process which has led to delays. It is perhaps helpful to note that this data reflects when the assessment is updated and signed off and not when it has actually been reviewed which generally occurs at the Annual CPA. It is perhaps also worth drawing attention to the fact that all patients at the State Hospital have a formal risk assessment based on the best practice approach in place.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2024	93%	91%	90%	91%	88%	89%	97%	95%	90%	97%	96%	96%

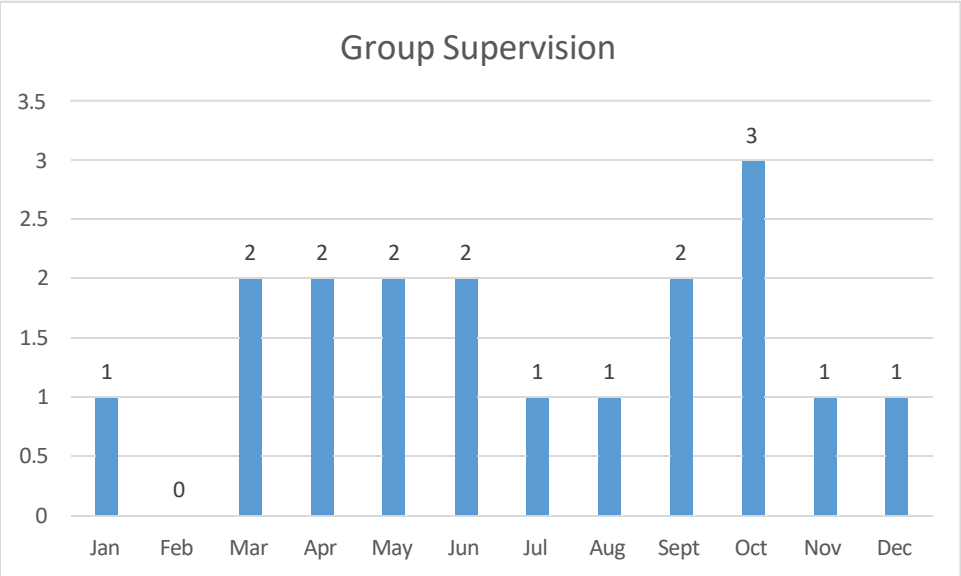


6 Quality Assurance Activity.

Members of the service are all subject to professional registration (reg HCPC, NMC or BABCP). Registration typically requires that continuing professional development and training are undertaken annually. This year training undertaken by staff within the psychology service includes in the use of structured clinical risk assessment tools and assessment of autism. One staff member has completed the first year of a CBT diploma and another has completed a post graduate certificate in the assessment of Foetal Alcohol Syndrome which will support the roll out of the Neurodevelopmental Assessment Pathway. In terms of therapeutic interventions staff have attended various training events including Compassion focussed therapy, eating disorders, motivational interviewing training and also training in CBT for PTSD.

Assurance activities such as completion of VATS is ongoing and has shown improvement this year. Auditing of supervision, having up to date clinical formulations and in relation to the quality of risk assessments will be reviewed this year. Under the National Specification, the Head of Psychology is expected to hold Governance of all psychological therapies being delivered in the Board and so this work will be taken forward as part of that. Since last year we have drafted a Terms of Reference for a Psychological Therapies Governance group; this has been agreed by the Clinical Governance Group and we are pleased to be able to report that the first group will meet in early February. This group will oversee these areas of work.

Clinical Supervision is an essential part of quality assurance and service delivery. The Service has recently written a supervision policy which details the expectations for individual supervision and group supervision for any therapeutic groups that they are involved in delivering. Adherence to this will be monitored through the PTGG. The team also deliver and attend group reflective practice sessions across the Hospital. The number of group supervision sessions provided by psychologists to all staff engaged in delivery of psychological therapy groups are shown below. A total of 18 sessions were delivered which is a slight increase on last year. According to the new policy which has just been agreed we would have expected there to be 40. This standard has been applied retrospective and has highlighting a recording issue which we can easily address



7 Quality Improvement Activity

7.1 Psychological data RiO.
The accurate recording and managing of data is an important aspect of ensuring that we can accurately report on the targets which are set to ensure a timely response to referrals for care. We continue to work on this and have greater confidence now that data is drawn from the RIO system. This work has identified an issue in relation to recording of indirect clinical work, for example risk assessment work. This is an issue for all forensic services and has been highlighted by the Heads of those services to the Heads of Psychology group. Within the State Hospital, we have raised this with the Head of Corporate Planning and Business Support and IT and are advised that a system solution is possible. Although as yet unconfirmed there may be an expectation that this is included as a psychological therapy under the National Specification and as such it will be important to record accurate data on this.

7.2 Risk Assessment and Management Process Review
As noted above all patients within The State Hospital have a violence risk assessment and management plan completed following the “gold standard” Structured Professional Judgment approach. These are updated at least annually. There are also clear procedural and physical risk management approaches within TSH which reduce the risk patients present. However, concerns have been raised by medium secure services regarding the quality of the SPJ risk assessments and in some cases these have resulted in difficulties transferring patients. A scoping exercise was conducted which included discussions with those services as well as TSH staff and the Scottish Government restricted patient team. This identified a number of common themes related to the assessment and plan, the clinical documentation, the process, training and gaps in auditing all of which are likely to be impacting the current quality, accuracy and utility of the risk assessments completed within the hospital.

Firstly, in relation to content, structure and format. The current process involves the assessments being completed in RiO mainly by cutting and pasting excerpts of information; there is no cohesive risk assessment report. This means the documents lack the required analysis and interpretation of previous violence, relevant risk factors or future risk and that the current RIO structure does not mirror the SPJ process in that the formulation or understanding of the risk is held separately; this can be difficult for stakeholders to access. Some of the main criticisms levied are that TSH risk assessments do not make clear what violence has occurred or that they do not explain risk. Further they are produced as un-editable PDFs which cannot then be easily updated by other services. Of particular concern is the approach to “scenario planning” which does not detail the information necessary to fully understand the nature of any future predicted violence. There are also issues with access to information and an apparent over reliance on collateral information from mental health case files. There is frequently limited information regarding past violent and offending behaviour or if it is present it lacks clarity; information is essential to fully understand risk. In some instances, information

about past alleged and actual offending has been completely unknown to the TSH clinical team, resulting in some areas of risk being unaddressed.
There are also some issues with some risk assessments not using the appropriate SPJ risk assessment tools which vary for different types of violence. When they are used the product is not easily integrated and these are written in separate word documents; which can mean there is a lack of cohesiveness which impacts on how effectively information about risk is communicated. Although there is audit of completion of the risk assessment there is not a process in place to audit the quality. It is also unclear at present to what extent the clinical teams use this information to plan the patients care and treatment or to inform other key decisions eg outings and there may be a reliance on more generic or procedure based approaches to risk management.

To date, some steps have been taken within the psychology department to begin to address these issues include producing written guidance for psychology staff on the key risk assessment processes, ensuring all psychologists have the requisite training and that they have access to risk assessment manuals. Changes to RIO are being explored and work is ongoing to update assessments in conjunction with medium secure colleagues so that assessments are applicable for areas with less physical and procedural security. A peer support "risk clinic" has been established and there have been initial meetings with security, social work, and health records in relation to access to information. As this is a long term and multi strand piece of work a clear work plan will be developed and shared with the Clinical Governance group.

8 Planned Quality Assurance/Quality Improvement for the next year

Theme	Leadership	Target	Evaluation
Governance of Psychological Therapies	HoP	Progress the work of the PTGG with regards to meeting the aim / objectives as outlines in the TOR.	January 2026
Review and improve of risk assessment process	Psychology / AMD/ Head of Risk	Continue to review current risk assessment process and make recommendations and implement change as required. To include ISP with Police Scotland and improved access to information as well as establishing an MDT risk group.	January 2026
Psychological group therapies.	Psychology Service	Plan for group delivery for 2025.	February 2025
Psychological group therapies.	Psychology Service	Review WT and Relaxation groups	July 2025
Staffing	HoP and consultant leads	Review staffing across the service and recruit to full PTS capacity as required.	Line management and Workforce Governance Group by Jan 2026
Physical health agenda.	Health Psychology / ID Consultant Psychologist	Support implementation of SHCIG workplan and evaluate service delivered by Health Psychology.	Audit, Feedback from other services, Patient feedback. By Jan 2026.
NDD pathway & training plan	Lead Psychologist for Admission Service.	NDD pathway to be piloted.	CGG oversight; By Jan 2026
Trauma-Informed Care	Psychology Service/ NPD and Trauma Champion	Increase TSH staff trained in NES Trauma-informed care and progress Trauma Roadmap.	Monitor numbers trained and establish a work plan for the Trauma Roadmap. By Jan 2026
Sexual Harm Service	HoP /ID Consultant Psychologist	Implement MF2C in collaboration with National Steering Group.	Training dates in June 2025.

Theme	Leadership	Target	Evaluation
Professional Practice	Chair of Professional Practice Group / HOP	Regular meetings to highlight any professional / clinical issues.	Attendance at group and links with Clinical Forum.