Guide to Delivering Psychological Therapies in Forensic Mental Health

Governance Manual for Managers and Service Providers

Contents

CHAPTER 1 - INTRODUCTION

This manual provides a guide to the delivery of psychological therapies in forensic mental health and learning disability settings.

It is intended for:

- Service Managers
- Heads of Psychological Services
- Clinical and Forensic Psychologists, as well as other Highly Specialist Psychological Practitioners
- Supervisors
- Staff delivering psychological interventions

This manual provides guidance for services, to best ensure effective delivery of psychological interventions in line with the ***matched stepped care model*** described in more detail below. It includes:

- An outline of the current menu of interventions;
- The governance arrangements that require to be put in place to support the delivery of interventions;
- The recommended care pathways for forensic patients;
- A step by step guide to the delivery of group based interventions as well as guidance on the processes for recording and reporting on patient progress;
- Information on staff training and supervision requirements; This includes reference to competency frameworks for both treatment delivery, forensic assessment skills and supervision
- A description of processes for evaluating treatment outcome.

Background to the matched stepped care approach

In the Forensic Mental Health Matrix: "A guide to delivering evidence based psychological therapies in forensic mental health in Scotland"[1], a matched stepped care model for the delivery of psychological interventions in forensic mental health services was proposed. The model takes account of the evidence-base, of patient needs, and of resource issues.

A set of programmes to support the model has been designed. Instead of focusing on specific mental health or offending problems, these programmes address the ***underlying needs*** which commonly contribute to these difficulties (see below).

What is the matched stepped care approach?

The matched stepped care approach is a way of separating out psychological interventions into levels of intensity, and then matching these levels to the competences of staff who can provide the interventions. This is in recognition that "many staff will have the competences necessary to offer specific, evidence-based psychological interventions as a core aspect of their work"[2].

[1] www.forensicnetwork.scot.nhs.uk/forensic-matrix

[2]The Matrix 2011 – A Guide to Delivering Evidence Based Psychological Therapies in Scotland (National Education for Scotland and the Scottish Government)

In this system the patient receives the minimum input compatible with effective treatment, and the model is therefore considered the best way to make use of limited resources. There should also be provision for patient choice.

It is recognised that low and high intensity interventions will not be sufficient for all patients. There will be a number of patients who will require highly specialist interventions before they can undertake group based interventions (e.g. patients with challenging behaviour), and many patients who will need to undertake additional work to address specific violent or sexual behaviour (e.g. individuals with sexual paraphilias or individuals who commit violence in the context of severe personality disorder).

Diagram 1.1 (below) gives some examples of forensic mental health services being delivered using a matched stepped care approach.

- **Motivational/engagement work, challenging behaviour interventions, systems-led PD interventions, CBT psychosis**

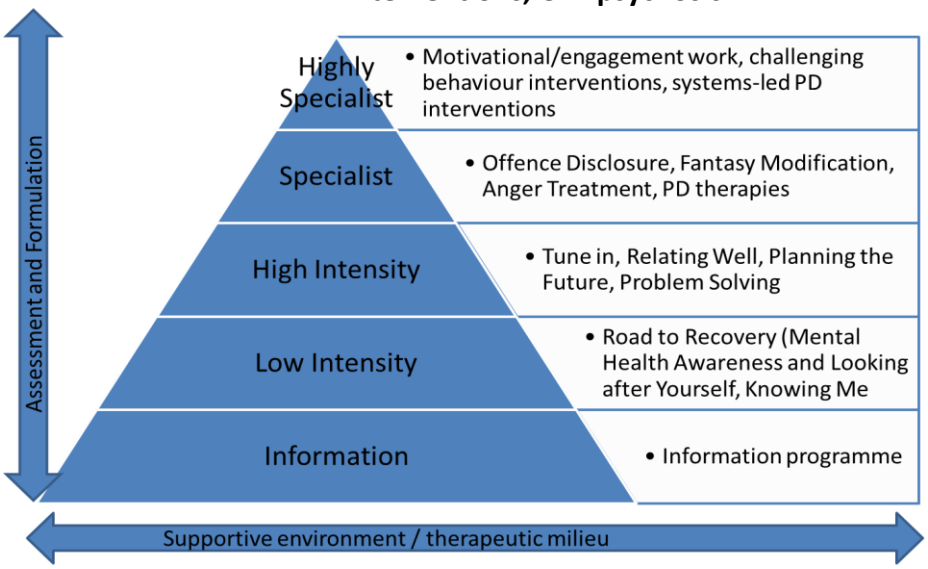


Diagram 1.1: Stepped care model for forensic mental health services with examples from the proposed model

The interventions referred to in the diagram have been developed to allow services to deliver psychological interventions across the varying levels of intensity, provided they have appropriately trained staff. Specialist and highly specialist interventions require high level formulation and therapeutic training, and will therefore continue to require the competences of highly specialist practitioners.

The low and high intensity interventions and their links to the equivalent problems, risk factors, and underlying needs are shown in the Table 1.1 below.

TABLE 1.1

Problem Behaviour / Risk Factor	Underlying needs	Intervention
Little or no understanding of mental disorder, how it can affect individuals, and how forensic services aim to help	Limited general understanding, knowledge, and insight	Information Programme
Poor insight	Poor insight into mental health problems, childhood and other trauma, and offending behaviour	Knowing Me
Childhood problems & early maladjustment	Poor insight into childhood and other trauma	Knowing Me
Major mental illness/active symptoms of mental illness	Poor coping skills, psychological distress, poor understanding of recovery ideas, stress and coping problems, problem solving difficulties, poor social skills	Information Programme, On the Road to Recovery, Planning the future
Substance misuse	Poor coping skills, psychological distress, poor understanding of recovery ideas, poor emotional awareness, poor control of emotions (over and uncontrolled anger, impulsivity) and use of unhelpful coping strategies, problem solving difficulties, poor social skills	Information Programme, On the Road to Recovery, Tune-in, Planning the Future
Stress/coping problems	Poor coping skills, psychological distress, poor understanding of recovery ideas, poor emotional awareness, poor control of emotions (over and uncontrolled anger, impulsivity) and use of unhelpful coping strategies, problem solving difficulties, poor social skills, impulsivity, negative attitudes etc	On the Road to Recovery, Tune-in, Problem-Solving, Planning the Future
Impulsive behavior	Poor emotional awareness, poor control of emotions (over and uncontrolled anger, impulsivity) and use of unhelpful coping strategies, problem solving difficulties, impulsivity, negative attitudes, etc	Tune-in, Problem-Solving
Mood disorders (depression, anxiety, anger, etc)	Poor coping skills, psychological distress, poor understanding of recovery ideas, poor emotional awareness, poor control of emotions (over and uncontrolled anger, impulsivity) and use of unhelpful coping strategies	Road to Recovery, Tune-in Individual CBT
Relationship problems	Poor social skills, coping problems, negative attitudes, emotional control problems, attachment issues, etc	Connections My Relationships and Relationship Skills
General offending	Problem solving difficulties, impulsivity, negative attitudes, etc	Problem-Solving
Negative attitudes	Poor social skills, coping problems, negative attitudes, emotional control problems, attachment issues, problem solving difficulties, impulsivity, negative attitudes, etc	Connections – My Relationships and , Relationship skills, Problem-Solving

Understanding Underlying Needs

There is an appreciation of the fact that moving from problem focussed interventions (e.g. anger management) to one of addressing underlying needs is a culture shift. Diagram 1.2 below, offers an explanation of underlying needs, and how a focus on underlying needs rather than problem behaviours may be more beneficial to patients when considering substance misuse and violence in the context of psychosis. The case of "David" demonstrates this model in relation to offenders with a learning disability.

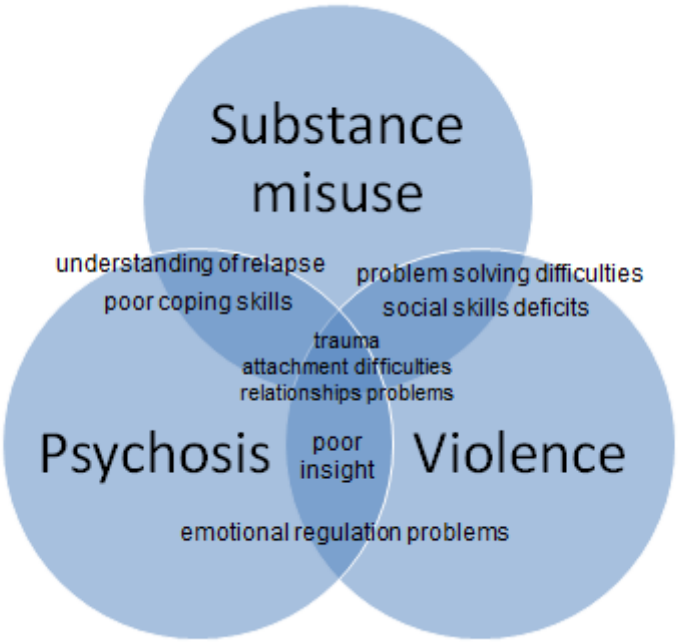


Diagram 1.2 Example Model of Underlying Needs across Problem Areas of Psychosis, Substance Misuse, and Violence

Case examples

Alan

Alan is a violent offender who murdered his partner in the context of a paranoid belief system where he believed that she was conspiring with others to cause him harm. He has a history of domestic violence.

In terms of psychological interventions, there may be a number of underlying needs related to both his mental disorder and his offending behaviour.

Underlying mental health needs:

- Need to develop an understanding of the causes of mental illness and the effects it can have on your behaviour
- Need to develop coping strategies for managing on-going symptoms related to persecutory ideation
- Coping with the trauma and stress of on-going memories of the offence
- Management of low mood

Offending behaviour needs:

- Recognition of problems with relationships and social skills
- Poor problem solving and impulse control
- Misogynistic attitudes and a sense of entitlement

Craig
Craig is a serious drug user who has consistently committed violent crime to fund his drug habit. He began to experience psychotic symptoms in prison and was transferred to hospital after he had committed a series of apparently random attacks on other prisoners. On admission he was very confused, and described command hallucinations to kill certain people who he believed were sex offenders.

Underlying mental health needs:
- Need to develop an understanding of the causes of mental illness (including drug use) and the effects it can have on your behaviour
- Need to develop coping strategies for managing on-going symptoms
- Need to undertake life history work to understand when and why he developed his drug habit
- Possible childhood trauma (sexual abuse) interventions

Offending behaviour needs:
- Poor coping skills, emotion regulation and impulse control
- Poor problem solving
- Pro-violence attitudes

Jim
Jim has autism, a mild learning disability and psychosis. He has a history of challenging behaviour, in particular violence towards paid carers. He struggles with changes to his routine and when under stress hears voices that tell him not to trust others. He had very recently been discharged from hospital to his own flat when he assaulted a member of staff.

Underlying mental health needs:
- Need to develop an understanding of the contribution symptoms of mental illness made to behaviour
- Need to develop understanding of how autism contributed to response to an unexpected change in staff behaviour
- Coping strategies for managing stress
- Need to develop strategies for managing on-going symptoms of psychosis

Offending behaviour needs:
- Recognition of problems with relationships and social skills
- Poor problem solving and impulse control
- Sense of entitlement, and other rigid beliefs following from autism and difficulty seeing things from others perspectives

All three patients have some common underlying needs. Once these are addressed there may well be more specific work that each man needs to undertake. Jim's staff will need to ensure they understand the challenges autism can present. Alan may need to look more closely at his history of domestic violence, and Craig may undertake specific relapse prevention work to enable him to avoid drugs in the future.

CHAPTER 2 - DESCRIPTION OF LOW AND HIGH INTENSITY PSYCHOLOGICAL INTERVENTIONS

All the programmes will be for use with patients who suffer from mental illness, personality disorder and, except the 'Information programme', for those with a learning disability.

INFORMATION PROGRAMME – "New to Forensic for Patients"

Who is it suitable for?	All forensic patients (adaptation by psychologist required for LD patients)
What underlying needs does it address?	General understanding and insight
Summary of content	Concept of recovery, understanding of forensic mental health system, mental health law, care team members and role, diagnosis/formulation, the effects of drugs and alcohol, risk, etc.
What is the delivery format?	One to one with key workers
Level of intensity	Information
Who can deliver?	Mental health professional inducted in the programme.
Who can supervise?	Senior staff member
Minimum frequency of supervision	One hour every four patient sessions
Minimum time per week for delivery	Once per week
Minimum number of staff to deliver	One
How long does the intervention last?	Variable according to the patient

KNOWING ME

Who is it suitable for?	All forensic patients
What underlying needs does it address?	Understanding of the development of mental disorder and offending behaviour with the aim of gaining insight into how childhood and life experiences have contributed to their situation. Helps prepare participants to engage in other psychological interventions.
Summary of content	Introduction to group work. Engagement and life history work. Genetic vs. environmental influences. Impact of life events. Good Lives Model. Introduction to attachment ideas.
What is the delivery format?	One to one or group
Level of intensity	Low
Who can deliver?	Staff with low intensity competences
Who can supervise?	High Intensity Psychological Practitioner or above*
Minimum frequency of supervision	No less than one group supervision session for every four sessions,.
Minimum time per week for planning, debrief and note keeping	Half an hour per session for individual work; 1.5 hours for groups
Minimum time per week for delivery	One hour per week for individuals; 2.5 hrs per week for group
Minimum number of staff to deliver	One for individual or two for group
How long does the intervention last?	Variable according to the patient

ON THE ROAD TO RECOVERY

Module 1: Awareness and Recovery
Module 2: Looking after Yourself
Module 3. Making Healthy Changes

Who is it suitable for?	Patients who suffer from major mental illness
What underlying needs does it address?	Poor coping skills, psychological distress, poor understanding of recovery ideas
Summary of content	Introduction of concept of recovery and early recovery planning, mental health first aid, tips for staying mentally healthy.
What is the delivery format?	One to one or group
Level of intensity	Low
Who can deliver?	Staff with low intensity competences
Who can supervise?	High Intensity Psychological Practitioner or above*
Minimum frequency of supervision	No less than one group supervision session for every four sessions.
Minimum time per week for planning, debrief and note keeping	Half an hour per session for individual work; 1.5 hours for groups
Minimum time per week for delivery	One hour per week for individuals; 2.5 hrs per week for group
Minimum number of staff to deliver	One for individual or two for group
How long does the intervention last?	Between 12-14 weeks for each module depending on the responsivity needs of the patients

TUNE IN

Who is it suitable for?	All forensic patients who have been violent, had substance-misuse problems, anger control problems, impulsivity, etc
What underlying needs does it address?	Poor emotional awareness, poor control of emotions (over and uncontrolled anger, impulsivity) and use of maladaptive coping strategies, e.g. substance misuse
Summary of content	Content includes: Understanding emotions, awareness and recognition of own and others' emotions, practical skills for managing emotions, problem-solving and constructive expression of feelings.
What is the delivery format?	One to one or group
Level of intensity	High
Who can deliver?	At least one member of staff with high intensity competences; co-facilitator may be trained to low intensity level
Who can supervise?	Highly Specialist Psychological Practitioner*
Minimum frequency of supervision	One group supervision session for every four sessions
Minimum time per week for planning, debrief and note keeping	Half an hour per session for individual work; 1.5 hours for groups
Minimum time per week for delivery	One hour per week for individuals; 2.5 hrs per week for group

Minimum number of staff to deliver	One for individual or two for group
How long does the intervention last?	Between 12-14 weeks depending on the responsivity needs of the patients

PLANNING THE FUTURE

Who is it suitable for?	Patients preparing to move on to conditions of lesser security who no longer experience acute psychosis.
What underlying needs does it address?	Stress and coping problems, problem solving difficulties, social skills deficits.
Summary of content	Staying Well and Good Lives planning, identification of high risk situations, dealing with temptation, exposure planning, focus on strengths, personal identity and lifestyle work
What is the delivery format?	One to one or group
Level of intensity	High
Who can deliver?	At least one member of staff with high intensity competences; co-facilitator may be trained to low intensity level
Who can supervise?	Highly Specialist Psychological Practitioner*
Minimum frequency of supervision	One group supervision session for every four sessions
Minimum time per week for planning, debrief and note keeping	Half an hour per session for individual work; 1.5 hours for groups
Minimum time per week for delivery	One hour per week for individuals; 2.5 hrs per week for group
Minimum number of staff to deliver	One for individual or two for group
How long does the intervention last?	To be decided

CONNECTIONS

Module 1: My Relationships, Module 2: Relationship Skills

Who is it suitable for?	Patients who have had poor relationships
What underlying needs does it address?	Social skills deficits, coping problems, negative attitudes, emotional control problems, attachment issues, etc.
Summary content- module 1	Appreciation of the importance of early attachment patterns in the development of and understanding of relationships and social skills; identification of factors which affect the ability to form positive relationships; consideration of how to maintain relationships once they are established
Summary of content – module 2	Building healthy relationships, practical relationship skills, attitudes/cognitive distortions, role-play, communication skills, assertiveness skills, etc.
What is the delivery format?	One to one or group
Level of intensity	Module 1: Specialist Module 2: High
Who can deliver?	At least one member of staff with high intensity competences; co-facilitator may be trained to low intensity level
Who can supervise?	Highly Specialist Psychological Practitioner*
Minimum frequency of supervision	One group supervision session for every four sessions
Minimum time per week for planning, debrief and note keeping	Half an hour per session for individual work; 1.5 hours for groups
Minimum time per week for delivery	One hour per week for individuals; 2.5 hrs per week for

	group
Minimum number of staff to deliver	One for individual or two for group
How long does the intervention last?	Module 1: to be decided Module 2: Between 12-14 weeks depending on the responsivity needs of the patients

PROBLEM SOLVING (some local availability / in development for the network)

Who is it suitable for?	Forensic patients whose offending behaviour is characterised by poor decision making or who are often in conflict with others
What underlying needs does it address?	Problem solving difficulties, impulsivity, negative attitudes etc.
Summary of content	Development of moral reasoning, fact vs opinion, problem-solving, planning, etc.
What is the delivery format?	One to one or group
Level of intensity	High
Who can deliver?	At least one member of staff with high intensity competences; co-facilitator may be trained to low intensity level
Who can supervise?	Highly Specialist Psychological Practitioner*
Minimum frequency of supervision	One group supervision session for every four sessions
Minimum time per week for planning, debrief and note keeping	Half an hour per session for individual work; 1.5 hours for groups
Minimum time per week for delivery	One hour per week for individuals; 2.5 hrs per week for group
Minimum number of staff to deliver	One for individual or two for group
How long does the intervention last?	Depends on intervention used

*These recommended minimum expected standards refer to the **level of practitioner generic competences together with specific supervision and forensic competencies,** as identified in the 'Competencies for the Delivery of Psychological Therapy in Forensic Mental Health Settings' framework section of this manual.

CHAPTER 3 - GOVERNANCE ARRANGEMENTS

It will be essential for each Board to have structures in place for the governance of psychological therapy in forensic services. This could be done either through an overarching clinical governance group, or a separate multi-disciplinary sub group responsible for clinical governance of the forensic psychological therapy service.

The governance tasks for each Board include:

- Accountability for the delivery of psychological therapies within the service.
- Ensuring regular assessment of the aggregated psychological needs of the patients within the service.
- Setting standards for staff delivering psychological therapies in line with national guidance (e.g. Matrix).
- Ensuring that each Board area has systems in place to support the standards (e.g. performance management, appropriate links between supervisors and line managers, follow up of training undertaken).
- Ensuring systems in place for monitoring the standards (e.g. waiting times, number of patients seen, completion rates, reports written, staff sessions used, other resources)
- Collating and reporting on monitoring and reviewing arrangement to the NHS Board.
- Ensuring staff competences are assessed and reviewed.
- Ensuring appropriate supervision systems and standards are in place to meet the needs of the staff who are delivering psychological therapies.
- Identifying and meeting staff training needs.
- Evaluation of outcomes for patients.
- Involvement of patients and carers.
- Review of ethical issues.

Key Developmental Questions for Services

The above guidance should form a template against which those who are responsible for delivering psychological therapies in forensic services can map their own services.

The following questions provide a checklist for those providers (that should be considered in addition to those on the current matrix):

Assessment of Need

1. Is there a system for conducting a forensic mental health risk assessment and management plan for all patients?
2. Is there a system for regularly reviewing and updating the risk assessment and management plan for each patient?
3. Is there a system for monitoring the aggregated need and planning the appropriate psychological interventions?

Strategic Planning

4. Does the organisation have a group of people who are taking forward the strategic direction of the psychological therapy service that meets both clinical and forensic needs?

Staff Competences

5. Are there enough suitably qualified highly specialist therapists who can formulate the needs of complex forensic patents and draw up individually tailored therapeutic interventions and supervise other practitioners in the delivery of the therapy?

6. Are services aware of the nature and level of competences required to provide each planned therapeutic intervention to their patients?
7. Is there a system in place to assess the competences of the staff who are delivering psychological therapies and provide extra training as required?
8. For those staff at different levels of training, are there clear guidelines about what type and intensity of psychological interventions they are able to provide?

Delivery of Psychological Therapy

9. Is the organisation able to deliver individual and group psychological therapy to meet the assessed needs of the patient group using appropriately qualified staff?

Training

10. Is there regular training in place for both risk assessment and management planning?
11. Is there regular training in place to develop all levels of staff in an understanding of how to work in a psychologically therapeutic way with patients?

Supervision

12. Are the supervision systems in place matched to the level of intensity of each intervention, as well as with the competences of the staff member providing the psychological therapy?
13. Are there systems in place to record and monitor clinical supervision practice?
14. Are there formal opportunities for reflective practice for all frontline clinical staff?

Evaluation

15. Are there appropriate evaluation systems (taking into account the methodological issues) in place for the therapies being delivered?

User and Carer involvement

16. Are there communication systems in place to support patient and carers engagement in the care and treatment process?

CHAPTER 4 - PATIENT PATHWAYS

People who come into forensic services have a variety of complex multi-dimensional psychological and risk needs. This documentation provides guidance which will assist with the identification of these needs, and help determine which psychological therapies may be appropriate.

Psychological risk and needs will be identified as a result of the multi-disciplinary assessment process. We recognise that this is done using different assessment tools in different health board areas. This guidance provides some information that may help multi-disciplinary teams determine which psychological therapies may be appropriate in light of information gathered from commonly used assessment tools (e.g. the BEST, CANFOR, and HCR-20; see flowchart 4.1).

After each assessment process, a number of psychological needs will be identified – some will be met by low and high intensity individual or group based interventions, whereas others may continue to be addressed by highly specialist interventions that are tailored to the individual needs of the patient.

Any psychological and risk needs identified, as well as related therapeutic recommendations, should be recorded and embedded within the CPA process. Psychological risks and needs should be regularly reviewed and updated in light of patient progress as part of this activity.

Flow chart 4.1 shows the process that services need to undertake to assess psychological risks and needs.

Table 4.1 shows which interventions are suitable for patients following assessment by the commonly used assessment tools.

Appendix 1 gives an example of how services might record psychological need.

Appendix 2 gives an example of a form to use to make referrals to psychological therapies

Consent to Treatment

Once patients are referred to treatment there needs to be clarity about the limits of confidentiality, and what their participation in a psychological intervention will mean. This needs to include the need to share information with other care team members, the limits of disclosure in a group or individual therapy setting, and consent to recording sessions for the purposes of supervision (if appropriate). Patients should also be made aware of other options to disclosure in treatment (i.e. via other clinical team members) as well as the possible effects of psychological therapy. That is, the aim is always to help individuals, but that this cannot be guaranteed for everyone. Consent will also include the need to collect routine outcome data, and the need to evaluate the intervention the patient is participating in. An example consent form is provided in Appendix 3.

FLOWCHART 4.1 - ASSESSING PSYCHOLOGICAL NEEDS & RISK PATIENT PATHWAY

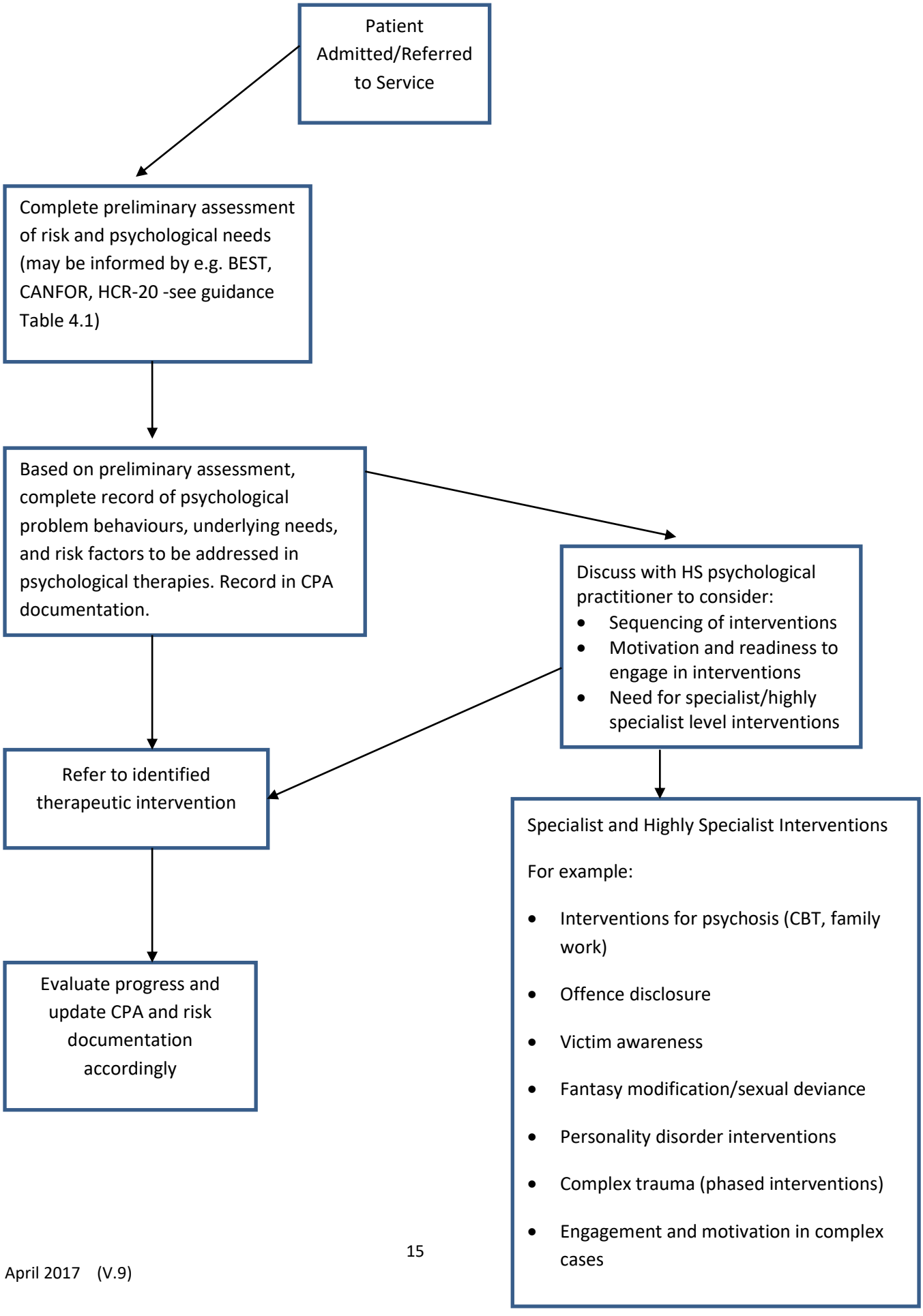


TABLE 4.1 – IDENTIFYING PROBLEM BEHAVIOURS AND RISK FACTORS FROM COMMON ASSESSMENT TOOLS & CORRESPONDING RELEVANT INTERVENTIONS

Problem behaviour/Risk factor and underlying needs	CANFOR	BEST Risk	Best Insight	BEST Communication/SS	BEST Empathy	HCR-20	Intervention /Group
• Lack of awareness and understanding of illness/mental disorder or risk. • Poor understanding of own psychological needs or difficulties. • History of problematic use of substances. • Distress caused by symptoms of mental illness.	7,8,9,12,13,23	Score of 1 or 2 on items 19 and 20	Score of 1 or 2 on items 1,2, 4 and 16	N/A	N/A	H5, H6, C1, C2,C3,C4	Information programme, On the Road to Recovery, Planning the Future
• Poor insight into mental health problems, childhood and other trauma and offending behaviour. • Need to understand self.	7,9,15	Score of 1 or 2 on any item	Score of 1 or 2 on item 16	N/A	Score of 1 or 2 on items 16, 19 and 21	H1,H2,H3,H4, H8,C1,C2, C4, C5, R1, R2,R3,R5	Knowing Me
• Poor emotional awareness • Unhelpful coping strategies e.g. anger, drug use or harmful sexual behaviour.	9,11,12,13,14, 24,25	Score of 1 or 2 on items within this subscale	Score of 1 or 2 on items 1-9 of this subscale	Scores of 1 or 2 on items 21, 26 and 30 of this subscale	N/A	H6, H9,C1,C3, C4,R2, R3,R5 (give more weight to clinical and risk items)	Tune in
• Poor social skills • Poor communication skills. • Intimate Relationship problems • Conflictual relationships (non-intimate).	11,14,15,16 24,25	Score of 1 or 2 on items 2, 3, 4, 5, 8, 9, and 15	N/A	Scores of 1 or 2 on any item within this subscale	Score of 1 or 2 on any item within this subscale	H3, H4, H7,H8, H9, C2, R2, R3,R4, R5	Connections
• Impulsivity • Difficulties in planning for the future • History of general offending • Lack of flexibility in thinking • History of problematic substance misuse • Self-harm • Self-efficacy	10,11,12,13	Low scores on items 2-15, and item 19 (i.e. item scoring 1 or 2)	Low scores on items 18, 19 and 20 (i.e. item scoring 1 or 2)	N/A	N/A	H1, H2, H3,H4, H5, H9, H10, C2, C4, R1, R2, R5	Problem Solving

CHAPTER 5 - DELIVERING PSYCHOLOGICAL INTERVENTIONS

Like all projects to be delivered, the delivery of group based psychological interventions requires a certain amount of organisation and coordination.

Table 5.1 provides a check list of what is required to deliver one group. This is repeated in Appendix 4 without the explanation so that it can be copied by managers and used for each intervention delivered.

TABLE 5.1: PSYCHOLOGICAL INTERVENTION DELIVERY CHECKLIST

TASK	RATIONALE	STAFF
PRE-GROUP		
Indentify highly specialist practitioner who has responsibility for the governance of psychological therapies	Although low intensity interventions can be supervised by high intensity practitioners the complexity and risk levels of the patients demand oversight by highly specialist practitioners	Highly specialist psychological practitioner
Identify group of patients requiring intervention using the appropriate assessment systems	Patients will not benefit from an intervention if they do not have the needs being addressed by the intervention or they are not at the appropriate motivational stage to enable learning of the material	Clinical team members and members of the psychological therapies team
Identify facilitators	Facilitators must be trained to deliver the intervention and sufficient in number to cover security needs and unplanned for absences	Service Manager
Ensure facilitators have enough protected time for the length the group is likely to run for PLUS time to complete reports at the end of the group	Psychological therapies must be delivered in a consistent manner at all times. This means the same time each week, with the same core staff. Preparation and debrief time plus further time for supervision must also be included.	Service Manager
Identify suitable venue for conducting the group	Ideally this should be the same venue each week. Facilities for security of group members and staff need to be considered as does provision for rest breaks and refreshments if desired	Service Manager
Identify group supervisor	This will be a high intensity psychological therapist or above* who is familiar with the intervention and has supervision competences.	Service Manager
Assess referrals	Assessment of referrals will check that the patient is motivated to attend the group, have the right needs and will identify future responsivity needs that may impact on the group. Consider disassociations, consider group dynamics. Select a group that is likely to work well together.	Facilitators and Supervisor
Ask patient to sign consent form to participate in the group	Consent forms allow the patients and the facilitators to be clear about the purpose of the intervention and the possible limitations	Facilitators

TASK	RATIONALE	STAFF
	of the work, including issues of confidentiality and consent to electronic recording	
Carry out pre-group psychometrics with each patient separately	These have two functions: the first to see if the individual patient makes progress, the second to enable aggregated data to be compiled to evaluate the effectiveness of the intervention overall.	Facilitators
Score pre-group psychometrics	Enables facilitators to see what specific areas of need patients may have	Facilitators and Supervisor
Identify targets for change for each patient	Facilitators will be alert to each patient in the group and what they hope that person will achieve	Facilitators and Supervisor
Pre-intervention meeting with facilitators and supervisor to plan delivery	This meeting ensures that all practical issues are covered and begins to think about the responsivity issues that might arise with the selected group of patients	Facilitators and Supervisor
Let patients know in writing when the group is due to start	It would be reasonable to give patients two weeks' notice of when the group will start and what day of the week it will run. It's important to stick to the date given to avoid disappointment. If any delay advise	Facilitators
Let clinical teams know in writing when the group is due to start	Clinical teams should be formally written to. Letters should indicate the title of the intervention along with a brief description of the group's aims, the start date of the group, the timing of the group each week and the approximate anticipated end date. Clearly this is subject to change according to the needs of the group members. The letter should also include the name of the facilitators, where the session notes will be recorded and an encouragement to the team to contact the facilitators at any time along with the expectations of named nurses / key workers. It should be explained that patients are expected to attend all sessions.	Facilitators
DURING THE GROUP		
Facilitators meet before each group to plan session	All facilitators need to be clear who will be leading each section and how they will work together to manage the patient group	Facilitators
Record each session using the organisation's note keeping system	Facilitators may want to keep separate session notes but these should aid end of session write up only and be shredded after the group	Facilitators
Meet supervisor at the appropriate frequency for each intervention	Supervision is an essential part of the governance process	Facilitators and Supervisor

TASK	RATIONALE	STAFF
Provide feedback to named nurses / key workers after each session re assignments, etc	Named nurses can provide good support to patients to practice and develop the skills they are learning during the psychological interventions	Facilitators
POST GROUP		
Carry out post group psychometrics	As above for both individual and group based evaluation	Facilitators
Score psychometrics	Allows comparison with pre-group questionnaires	Facilitators and Supervisor
Facilitators and supervisor meet to go over patients' progress and plan the report writing	Supervisors may need to give some guidance on the emphasis needed in each patient's report	Facilitators and Supervisor
Allocate reports to be written to each member of the facilitator team. Allow 6 weeks maximum for completion	If the same time that was available to run the group, is allowed for the write up, it should be achievable to write reports within a 6 week period. Reports are the main way that patients show their participation and improvement	Facilitators
Supervisor reads and signs off the reports	Supervisors should countersign reports	Supervisor
Facilitators meet with each patient to go over their report and explain findings	This process allows patients to feel that they are part of the report process and should have an option to record their views of the report	Facilitators
Reports sent to clinical team (and other appropriate professionals) and patient	Patients mostly do want copies of their reports but may equally choose not to. However they should be offered the choice	Facilitators
Meet with key members of the patient's usual clinical team to discuss patients' progress and next steps	Integration of the learning patients have made during group work needs to be reinforced by the current care team	Facilitators

Integration of Patient Learning

Practice of new learning is widely recognised as an important way that patients consolidate and integrate the skills they have acquired during their psychological intervention into their everyday life. It is therefore essential to keep close communication with the patient's care team, ensuring that they understand what the patient is learning and what skills they are attempting to practice. In particular they will be able to help the patient identify situations where the application of their skills would be helpful as well as providing positive reinforcement of success.

The Recovery File

One of the main aims of forensic mental health interventions is for patients to learn to develop ways to self-manage, both their mental disorder and their potential risk of harm. As part of this process psychosocial interventions aim to help patients increase their sense of self-efficacy, self-esteem and compassion for oneself and others. The Recovery File belongs to the patient. The format can be variable but in essence it is a way of helping the patient record their recovery journey. They can use it

to keep the work that they undertake on the different psychological or other interventions; they can record their thoughts and feelings and keep copies of the reports written about them.

There are a number of possible formats for this on the forensic matrix section of the forensic network website (see www.forensicnetwork.scot.nhs.uk/forensic-matrix/resources)

It is suggested that facilitators encourage and support their patients to develop their own recovery file.

Processes and Record Keeping

Record keeping processes must be in keeping with the organisation's and professions current systems.

The facilitators will want to keep their own notes about topics for future groups, and where these are not patient related, they can be kept in a group file. Patient identifiers but not patient names should be used in this system.

Where recording devices are used, these should be for the purposes of supervision only. Each organisation will have its own policy on the management of electronic media in accordance with data protection act and the Caldecott Principles. The general rule is that any electronic recordings should always be kept secure and then destroyed in accordance with local procedures once the purpose of supervision has been achieved.

Note Keeping following Treatment Sessions:

It is essential that records are kept following each patient contact, and this should be done in line with the record keeping policy within each board. As well as being good and necessary practice, note keeping after each session will also assist with report compilation at the end of treatment.

It is suggested that a note keeping pro-forma with the following headings is used:

- Attendance and Engagement
- Comprehension
- Progress and Outcomes
- Recommendations

In each session the facilitators should focus on reporting the progress made on the each patient's treatment targets that were identified in the early sessions of the programme. These notes should however be brief and succinct, and there may not always be something to record under each heading following every session. For more information on the sorts of information that would be useful to record, see the section on end of treatment report writing below.

End of Treatment Report Writing Guidance for Low Intensity Interventions:

Progress reports completed by facilitators at the end of therapy are an important part of the patient's treatment. They should be shared with the patient so that they have an understanding of the progress that has been made, any difficulties that may have been encountered, and any recommendations that may be made for future therapy or maintenance work. Reports are also important for multi-disciplinary teams as they communicate outcomes and can then be used to inform risk assessment and management.

Despite the utility of end of treatment reports, experience has demonstrated that if reports are too long or complex, they become less readable and useful to both staff and patients, and can take much more time to complete. Lengthy reports are therefore not necessary, and in some instances can actually be unhelpful. It is therefore recommended that reports are no longer than 2-4 pages, and that information is split into four sections: attendance and engagement; comprehension; progress & outcomes; and

recommendations. Guidance is given as to what sort of information should be included in each section below. All end of treatment reports should be completed under the designated supervisor.

A report template has been provided for guidance in Appendix 5.

Attendance & Engagement

- How many sessions did the patient attend? If they missed any sessions, what was the reason for this?
- Did they appear motivated to engage in treatment? If so, what reasons did the patient give for wishing to engage (note that these reasons may have changed as treatment progressed)? If not, why might this have been the case?
- What was their engagement like during treatment? Did they participate in group discussions and exercises? Did they complete homework tasks?

Comprehension

- Do you feel that the patient understood all aspects of the treatment? Were there any parts they found difficult, or any parts that they seemed to grasp particularly well?
- If there were any problems with comprehension, can you comment on why this might have been the case?

Progress & Outcomes

- What benefits did the patient gain from attending treatment? Comment on both objective and subjective changes.
- Strengths and weaknesses
- Were any specific skills developed? If so, was there evidence of these being generalised out with the treatment setting (e.g. in the ward, in their community work placement)?
- Provide a very brief statement summarising any significant changes noted in pre and post psychometrics. The supervising psychologist can help with the interpretation of results. This should not involve lengthy descriptions of measures used or detailed breakdowns of test scores. You may wish to comment that the reader can contact the supervising psychologist if they require a more detailed explanation of the psychometrics and the patient's scores.

Recommendations

- Comment on any additional needs identified through the course of treatment.
- Is additional more highly specialist work indicated to address the underlying need further?
- What recommendations would you make to help the MDT support the gains made by the patient in treatment?

CHAPTER 6 - STAFF TRAINING REQUIREMENTS AND DEVELOPMENT OF COMPETENCES TO DELIVER PSYCHOLOGICAL THERAPIES

Staff training requirements

One of the aims of the matched stepped care model of delivering psychological interventions is that psychological interventions can be delivered using a skill mix of staff, not all of whom need to have high levels of psychological expertise and training.

Services can therefore deliver the matched stepped care approach using staff with different levels of skills and competences, provided this is underpinned by the appropriate governance arrangements (see chapter 3). Central to this is good supervision of the psychological therapies staff. One highly specialist psychological therapist can be responsible for the delivery of a number of low and high intensity groups and pieces of individual work. **However, without any highly specialist staff no interventions can be delivered safely at all**.

This chapter outlines the range of competences and training those services will require from their staff before psychological interventions can be delivered.

Table 6.1 outlines the level of training required for each intensity of psychological intervention. This has been adapted from the original matrix work (NES, 2011) to meet the needs of forensic patients.

Table 6.1 outlines the level of training required (including clinical supervision training) for each intensity of psychological intervention. This has been adapted from the original matrix work (NES, 2011) and the updated matrix (NES, 2015) to meet the needs of forensic patients.

Level of therapy	**Intervention**	**Training Required/competences**	**Supervisor Training Required/competences**	**Options in forensic services**
Low Intensity	On the Road to Recovery Knowing me	5-10 days training required plus intensive, ongoing clinical supervision	Supervisors trained in and delivering High Intensity therapy (or above) who also have forensic and supervision competences (e.g. NES Generic Psychological Therapies Supervision Course or NES CBT-specific Supervision training) as described in the competences framework *'Competences for the Delivery of Psychological Therapy in Forensic Mental Health Settings'* (Also, a supervisor who is not a psychologist, e.g. a CBT Therapist, would normally be expected to have two or three years of experience of delivering the therapy under supervision (after having completed their therapy training), plus support from management for their application, before putting themselves forward for supervisor training).	NES –Low intensity Psychological Interventions in Forensic Mental Health Settings
High Intensity	Tune In Planning the Future Problems solving Connections – Relationship Skills	Diploma level Normally at least 24 days formal teaching, 24 days CBT in the workplace, plus intensive supervision over at least 1 year of training	A highly specialist psychological therapist with a working knowledge of, and substantial experience in, the delivery of the intervention in which they are providing supervision, AND will have training which equips them with the 'Skills for Health'* supervision competences.	As for other services – see NES "The Matrix" (2011)

Level of therapy	**Intervention**	**Training Required/competences**	**Supervisor Training Required/competences**	**Options in forensic services**
High Intensity – Specialist	Interventions are those that follow a specific model of treatment but not a prescriptive protocol. The interventions themselves are generally targeted at patients with more complex risk and needs and are directly related to offending behaviour and its causes. They will remain formulation driven and are capable of adapting to the responsivity needs of the patient. Examples: sex and violent offender and PD interventions; My Relationships	Diploma level CBT training plus further training in application of CBT techniques to specialist area. Further knowledge and skills may be acquired through formal training or through specialist supervision	As above	As for other services – see NES "The Matrix" (2011)
Highly Specialist	Interventions that must be individually tailored to the patient's risks and needs drawing on the theoretical knowledge base of psychology and risk assessment and management. Highly specialist intervention for specific problem types.	Specialist knowledge of a range of theoretical and therapeutic models. Ability to formulate complex problems using a range of psychological models, taking into account historical, developmental, systems and neuropsychological processes.	As above. (At the highest tier staff receive supervision from peers).	As for other services – see NES "The Matrix" (2011)

Level of therapy	**Intervention**	**Training Required/competences**	**Supervisor Training Required/competences**	**Options in forensic services**
	Examples: Violent offender with psychosis and/or challenging behaviour. Stalking. Fire raising			

Supervisor Tasks (may be shared between supervisors of different levels of intensity):

Supervisors of staff who are delivering psychological interventions in forensic services have a number of tasks and responsibilities:

- Ensure the assessment and allocation of patients to the specific intervention has been carried out appropriately to ensure that the patient is both capable of participating in the group at the point in time they have been referred and is at the right stage in their recovery journey to undertake the work.
- Understanding each patient's psychological and risk formulation and how the intervention may help.
- Ensure that the facilitators are aware of the responsivity needs of each patient and can adapt their group delivery style accordingly.
- Ensure that the risk of harm to others has been adequately assessed using a structured professional judgement approach for each patient and that the impact of this is taken into account both for the day to day delivery of the intervention and the impact the intervention is likely to have on the patient in terms of reducing their future risk to others.
- Observe or listen to recordings of sessions.
- Ensure that the facilitators both understand and can manage the group dynamics of each group given the groups are likely to be made up of individuals with complex enduring mental health problems with high likelihood of co morbidity (e.g. substance misuse, personality disorder, cognitive impairments etc).
- Supervise potentially inexperienced therapists to deliver a simple intervention to a complex group of individuals.
- Have expertise in the supervision of others and in particular the delivery of constructive feedback and an emphasis on skills and competences development.
- Supervise the administration, scoring and interpretation of psychometrics.
- Supervise the record keeping of individual sessions as well as the end of group reports.
- Ideally will have completed NES Generic Psychological Therapies Supervision Course (or equivalent). Supervisor should demonstrate supervision competences as outlined by NES (http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/training-psychologists/clinical-supervision/nes-training-in-generic-supervision-competences-for-psychological-therapies.aspx).
- Evaluate the competences of their supervisees and support the development of their therapeutic skills.

It is recommended that supervisors of interventions meet with facilitators no less than once every four sessions. This is likely to be more frequent for less experienced facilitators.

Competences for Delivering Low and High Intensity Interventions

Each facilitator will be at different stages in their development as a facilitator when they begin delivering group and individual psychological interventions. Depending on their level of training, they will be working towards developing the full range of skills for their level. Supervisors are responsible for the ongoing assessment of the competences of the facilitators as well as identifying areas for development.

For all low intensity interventions described supervisors will be trained in CBT and have demonstrated competences in the CBT model to a high intensity level or above.

For high intensity interventions described supervisors will be trained in CBT and have demonstrated competences in the CBT model to a specialist or highly specialist level.

A document developed to list the competences for delivering psychological therapy in forensic mental health settings can be found on the Forensic Network website at: www.forensicnetwork.scot.nhs.uk/forensic-matrix/governance. The competences required for delivering low and high intensity interventions are also indicated on the competency list

The competences are listed under the following headings:

1. Engagement
2. Forensic mental health assessment
3. Risk formulation and management
4. Clinical Formulation
5. Psychological interventions in a forensic setting
6. Team working
7. Supervision
8. Professional and Ethical Considerations for working in forensic psychological therapies
9. Understanding the legal framework for mental health and criminal justice
10. Basic CBT competences
11. Specific CBT competences
12. CBT specific metacompetences

Individuals who are delivering psychological interventions are expected to be familiar with the competences required for the level of intervention they are delivering. They should then identify these with their supervisor and develop a plan to work towards achieving competency in each area.

CHAPTER 7 - EVALUATION

What is Evaluation?

Evaluation offers a way of determining whether an intervention has been successful in terms of delivering what was intended and expected. It is important to know that it was the psychological intervention that made the difference to the patient's reduction in symptoms or decrease in violent behaviour and not some other unknown or unmeasured activity that may have taken place at the same time.

With this in mind we want to try and evaluate all interventions in a systematic way.

Programmes should therefore be evaluated in terms of:

1. Does it work for this patient, in terms of reduction in symptoms, distress, behaviour change, risk of future harm (**outcome data/clinical indicators**)?
2. Is the intervention as whole working for a group of patients (**outcome data/clinical indicators**)?
3. Do the patients like participating – does it engage them? (**service user and carer satisfaction data**)
4. Are the proscribed techniques used in the intervention working in the way they were intended to? For example, is it the specific cognitive-behavioural techniques or the supportive nature of the group – or both that make the key difference in treatment (**process measures**)?
5. Is the organisation able to appropriately identify treatment needs and provide relevant interventions– evaluating effectiveness at a psychological services level?

Why is Evaluation Important?

Evaluation can also answer other important questions. Apart from measuring a programme's outcomes and impact, it can also influence future programme planning and design as well as providing information about whether the resources provided for a programme were justified.

It should be noted that the lack of evidence in relation to an intervention and its effectiveness should not be construed as evidence for its ineffectiveness. Evaluation of programmes allows for evidence for their effectiveness to be gathered.

Routine measurement of data related to outcome generally is also an important aspect of service evaluation, as it provides information on outcomes in an accessible format and is viewed as important in improving quality and accountability. This can be through a combination of core data gathered on all service users, and specific outcome measures selected as being relevant to a psychological intervention.

What data needs to be collected?

1. *Does it work for this patient, in terms of reduction in symptoms, distress, behaviour change, risk of future harm (**outcome data/clinical indicators**)?*

Outcome data

Through the use of the appropriate outcome measures as suggested in the programme-specific guidance, the expectation would be that there would be an objectively observed clinically significant change between the pre and post-intervention time points, or a trend towards this, for individuals. Details of the identified programme-specific outcome measures and what would constitute clinically significant change can be found in the introduction to each programme manual.

Clinical indicators

In addition, changes in identified needs should be observed for individual patients. Given that the needs assessment tools in common usage have not necessarily been validated for use as change measures (e.g. BEST, CANFOR) the level of change is likely to be at the item level, rather than summary scores, such as total number of needs and so on. Similarly, at an individual level, changes in risk status should be tracked. For example, changes in ratings of items in the HCR-20 which relate to the stated aims of a psychological intervention should provide an indication of outcome (such as a coping skills intervention affecting ratings on item R5 Stress), as should progress through the rehabilitative system. Other measures (eg datix events) can also be used.

2. *Is the intervention as whole working for a group of patients (**outcome data/clinical indicators**)?*

Essentially, this means ensuring that the intervention does what it is designed to do, so that by addressing identified underlying needs, there should be an effect on problem behaviour for all the group members. This relates to outcomes from treatment.

In reality the outcomes for each patient undertaking the intervention will vary significantly, in that some will greatly benefit, some will gain some benefit and some none at all. By looking at the outcome data for the group as whole, or even better, a number of groups, the service will begin to learn whether the intervention is suitable and effective for their patients.

Analysis of group data requires some research and statistical skills; the first step in often to set up a database of all patients and their ratings on the agreed measures.

3. *Do the patients like participating – does it engage them? (**service user and carer satisfaction data**)*

Post group rating sheets for patient satisfaction can be collated but qualitative techniques can also be useful here. This could take the form of arranging interviews with participants after completion of the intervention using a standardised semi-structured interview protocol (see forensic matrix website resources section for example). The resultant data could then be subjected to a process of thematic analysis. Thematic analysis allows for identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes the data set in (rich) detail. This analysis should be undertaken by those with a grounding in research methods and some familiarity with qualitative research methods.

4. *Are the proscribed techniques used in the intervention working in the way they were intended to? (**process measures**)?*

Process measures detect genuine differences in quality and can be more sensitive than outcome measures. They are a direct measure of e.g. adherence to CBT principles, so if outcomes suggest change without this being reflected by process measures, alternative explanations should be sought, rather than attributing to the programme. If process measures support outcomes, suggests that e.g. programme may be the mechanism of action (not some other unmeasured variable).

5. *Is the organisation able to appropriately identify treatment needs and provide relevant interventions – evaluating effectiveness at a psychological services level.*

Evaluation at this level requires data from a number of sources. The system must be able to ascertain that needs in the patient population are being appropriately identified. Then the system must be able to track that there are interventions in place that aim to address the identified need. The effectiveness of the interventions should be assessed at a group level, and the system must be able to track progress through the rehabilitative system. Subsequent needs assessments should reflect that previously identified needs have been met, and re-referrals to programmes should be recorded. A number of factors can affect the effectiveness of programmes, including skill level of the facilitators, and data should be gathered on programme delivery, along with dropout rates.

What measures should we use and how should we use them?

Programme specific outcome measures

Recommendations on the appropriate outcome measures for specific programmes are included on the Forensic Matrix website, along with copies of the measures and electronic scoring templates.

The mandatory data set

It is recommended that there are certain minimum requirements for assessment for **all interventions** (see below). For each specific intervention there will also be a number of additional outcome measures specific to the issues targeted by the programme that should be employed.

1. *Generic guidelines – minimum requirement for all interventions*

The Clinical Outcomes in Routine Evaluation assessment (CORE-OM[3]) ((Evans et al, 2002) - see below - should be used on admission to services and prior to review e.g. CPA. The Government guidance further recommends administration at start, middle and end of treatment. There remains a lack of clarity over whether the Learning Disability version of the CORE is suitable and should be used at the service's discretion.

CORE-OM, a 34 item generic self-report measure of psychological distress comprising of 4 domains (well-being, symptoms, functioning, risk).This can be downloaded from the Clinical Outcomes in Routine Evaluation website at: www.coreims.co.uk/Downloads_Forms.aspx. For non-LD services please ensure that the 34-item item version of the CORE is used, and not other versions.

Patient satisfaction question should be administered post-group (Appendix 7 and 8)

1. *Time points for measurement (see Appendix 9 Evaluation checklist)*

Best practice recommends that outcome data is collected not just pre and post an intervention but at various other time points. Ideally there would be a period where the patient is assessed but no intervention takes place. This is to allow us to contrast the changes in the patient during the intervention period with the time they are receiving no intervention. If we see changes on outcome measures during the intervention period and not in the pre-group stage; this would suggest the intervention, rather than other events are helping the patient change.

[3]Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., McGrath, G.,Connell, J., Audin, K. (2000), Clinical Outcomes in Routine Evaluation: The CORE-OM. *Journal of Mental Health*, 9, 247–255

The following assessment points are recommended:

- At time of referral – the waiting list control period at least 10 weeks before intervention begins.
- Immediately pre group
- Mid way through intervention or once every 10 sessions for long interventions
- Post group
- Follow up- approximately 12 weeks. This is to demonstrate any maintenance of any treatment gains.

2. Scoring and storage

Each individual psychometric will have its own scoring guidelines and manual. It is imperative that all group facilitators are familiar with the scoring procedures and are appropriately trained to administer these.

It is recommended that all psychometrics should be scored immediately after administration so any pertinent clinical or risk issues can be flagged to clinical teams/ group facilitators. The psychometrics should be held within the patient files.

At the end of the programme, analysis of the psychometric data should be undertaken, this should take the form of comparing the time points, and looking for clinically significant change – this will depend on the psychometrics used.

3. Feedback and reporting

Upon completion of the group programme, psychometric results should be shared with the group facilitators. A summary should also be provided to patients. It is recommended that a description of change, positive or negative should be fed back to the patient, e.g. "prior to the group starting you self reported feeling anxious and agitated all of the time, but when you were reassessed after the group, you reported that you now only feel this way some of this time", rather than an exact figure so it is NOT appropriate to write: *"you scored 30 pre group on X psychometric and 20 post group".*

APPENDIX 1: EXAMPLE OF METHOD OF RECORDING PSYCHOLOGICAL NEEDS

Patient name:
CHI:
Psychologist:

Identified risk/psychological needs	Date identified	Intervention plan (consider delivery i.e. 1:1 or group and also sequencing of multiple interventions)	Goal of intervention

Completed by: …….

Designation:……..

APPENDIX 2 EXAMPLE REFERRAL FORM

Psychological Therapies Service – Referral Form

Name:----------

D.O.B……CHI…….. …….. D.O.A……..

R.M.O…….. Ward……..

Please tick the box of the psychological therapy you wish to refer to: If you wish to refer to more than one, please indicate which one you wish to prioritise.

INFORMATION		
KNOWING ME		
ON THE ROAD TO RECOVERY:	Module 1:	Awareness and Recovery
	Module 2:	Looking After Yourself
TUNE IN		
RECOVERY 2		
CONNECTIONS:	Module 1:	My relationships
	Module 2:	Relationship skills
PROBLEM SOLVING		
INDIVIDUAL CBT		
OTHER	↑	

In what ways do you hope the patient would benefit from the therapies noted above?

Does the patient have any known literacy or learning difficulties with which they require additional support?

Describe any safety & security issues (e.g. escort status, access status: See guidance below):

Has this referral been discussed with the potential participant? Yes No

If No please give reasons for this……

Guidance on safety & security issues

Please ensure that any issues are highlighted and requests made about the need for male staff, number of escorts etc are explained, for example, clarifying whether requesting a male refers to facilitator or escort. These should be determined by the clinical team and be consistent with escort status in the grounds and community, and access status e.g. for the community centre.

The clinical team should consider the presence of issues which may inhibit any individual's ability to benefit from **group** psychological therapy. This includes at the point of referral and at the point of projected intervention. Points for consideration include:

- Supervision and monitoring status (e.g. escorts/observation level), particularly in relation to procedural/relational security
- Association status with particular peers
- Current mental state
- Involvement in concurrent psychological therapy and possible contraindications (group or individual)

The team may wish to consider whether the identified need be better met through a 2:1 intervention, rather than in a group?

Please list those present at clinical team discussion of referral:

Signed:

Clinical Psychologist…….. **Date**…….

RMO……**Date**…….

APPENDIX 3: CONSENT TO PARTICIPATION IN PSYCHOLOGICAL THERAPY

Request for Consent to Participate in **XX**

CONSENT FORM

Name of person being asked to take part in the treatment

……..

Please Circle	**YES**	**NO**
Have you read the information sheet?	YES	NO
Have you had a chance to ask questions?	YES	NO
Have your questions been answered?	YES	NO
Have you talked to anyone about this?	YES	NO
If YES, who have you talked to?		
……		
Do you know that you can change your mind?	YES	NO
Do you think it is OK for me to tell other people who work		
with you about what we talk about in the sessions?	YES	NO
Have you got all the information you want?	YES	NO

Participants Signature ……..

Name in Block Letters ……..

Date ……..

Witness Signature ……..

Relationship to Named Person ……

Name in Block Letters ……..

Date ……..

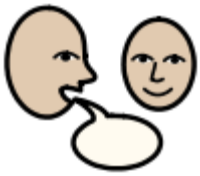
APPENDIX 4: ADAPTED CONSENT TO PARTICIPATION IN PSYCHOLOGICAL THERAPY

Request for Consent to Participate in the ……. Group

CONSENT FORM

Name of person being asked to take part in the group

……..

	Please Circle	**YES**	**NO**
			
Have you been informed about the ….. group?		YES	NO
			
Have you had a chance to ask questions about the group?		YES	NO

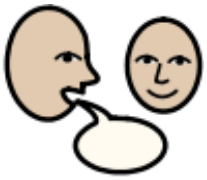
Have your questions been answered? YES NO

Have you talked to anyone about this? YES NO

If YES, who have you talked to?

……

Do you know that you can change your mind? YES NO



Do you think it is OK for me to tell other people who work with you about what we talk about in the sessions? YES NO

Have you got all the information you want? YES NO

Participants Signature ……..

Name in Block Letters ……...

Date ……..

Witness Signature ……..

Relationship to Participant ……

Name in Block Letters ……..

Date …….

APPENDIX 5: CHECKLIST FOR DELIVERY OF PSYCHOLOGICAL INTERVENTIONS

Intervention: Start Date:

Facilitators: Supervisor:

TASK	STAFF	DATE COMPLETED
PRE-GROUP		
Identify group of patients requiring intervention using the appropriate assessment systems	Clinical team members and members of the psychological therapies team	
Identify facilitators	Service Manager	
Ensure facilitators have enough protected time for the length the group is likely to run for PLUS time to complete reports at the end of the group	Service manager	
Identify suitable venue for conducting the group	Service manager	
Identify group supervisor	Service Manager	
Assess referrals	Facilitators and supervisor	
Ask patient to sign consent form to participate in the group	Facilitators	
Feedback to patients not selected	Facilitators	
Score pre-group psychometrics	Facilitators and supervisors	
Identify targets for change for each patient	Facilitators and supervisors	
Pre-intervention meeting with facilitators and supervisor to plan delivery	Facilitators and supervisor	
Let patients know in writing when the group is due to start	Facilitators	
Let clinical teams know in writing when the group is due to start	Facilitators	
DURING THE GROUP		
Facilitators meet before each group to plan session	Facilitators	
Consider patients' progress in relation to identified treatment targets during each session, review/revise treatment goals	Facilitators with support from supervisor	
Meet supervisor at the appropriate frequency for each intervention	Facilitators and supervisor	
Provide feedback to named nurses after each session re assignments, etc	Facilitators	
Score psychometrics	Facilitators and Supervisor	
Facilitators and supervisor meet to go over patients progress and plan the report writing	Facilitators and supervisor	
Allocate reports to be written to each member of the facilitator team. Allow 6 weeks maximum for completion	Facilitators	
Supervisor reads and signs off the reports	Supervisor	
Facilitators meet with each patient to go over their report and explain findings	Facilitators	
Reports sent to clinical team	Facilitators	
Reports sent to patient	Facilitators	
Meet with key members of the patient's usual clinical team (key workers, named nurse, CPN, RMO, OT etc) to discuss patients progress and next steps	Facilitators	

APPENDIX 6: REPORT WRITING TEMPLATE

[Insert Psychological Therapies Programme Title]

End of Treatment Report

Patient Name:

CHI Number:

Attendance & Engagement

Comprehension

Progress & Outcome (including the results of the psychometric assessments)

Recommendations

APPENDIX 7: PATIENT SATISFACTION QUESTIONNAIRE

Post-group Evaluation: Patient experience of the intervention

Patient: **Chi No:**

Ward: **Date:**

Please state the specific group intervention:

……

How helpful was the group for you? (Please tick)

1 – Not at all helpful ☐

2 – Quite unhelpful ☐

3 – Neither helpful nor unhelpful ☐

4 – Quite helpful ☐

5 – Very helpful ☐

APPENDIX 8: ADAPTED PATIENT SATISFACTION QUESTIONNAIRE

Name:

Group:

Chi
Number:

Date:

The group helped me (please circle):

Not at all **A little** **Quite a bit** **A lot**

APPENDIX 9: EVALUATION CHECKLIST

INTERVENTION:

TIME	TASK	COMPLETED
At point of referral.	Administer the following Psychometrics : (1st base line measures)	
	CORE – 34	
	INTERVENTION SPECIFIC MEASURES *(See Forensic Matrix website for intervention specific measures)*	
	Score assessments, record time point and put in patient file	
Week before start of interventions	Re- administer Psychometrics: (pre-group)	
	Score assessments, record time point and put in patient file	
After each session	Complete process measures specific to each programme – see Forensic Matrix website for more details	
Mid way through intervention	Re- administer the Psychometrics **(or once every 10 sessions for long interventions)**	
	Score assessments, record time point and put in patient file	
End of programmes	Re- administer the Psychometrics (post group) Now also include: ***Patient satisfaction questionnaire***	
	Score assessments, record time point and put in patient file	
12 week follow up	Re- administer the Psychometrics	
	Score assessments, record time point and put in patient file	