

# Development and implementation of a gender specific psychological treatment pathway in low secure services within Raphael Healthcare



Raphael Healthcare

## Objective:

In 2006 Raphael Healthcare opened its first low secure female unit initially with 30 beds, this has now increased to 46. The aim was to develop a psychological individualised gender specific forensic treatment pathway, focusing on current best practice.

## Methods:

- This has been achieved by the following:
- Needs analysis of gender specific areas**  
After setting up a skeleton service and attending all ward rounds and MDT meetings, we were able to implement and use a questionnaire / referral sheet completed within ward round with patient involvement looking at problem areas and therapies which could be used to address this.
  - Accessing current best practice guidelines and training**  
Strong links with UK and European trauma societies have greatly influenced our tailored pathway. Training has also been provided to staff on working with PD, substance misuse training, schema awareness training and specialist training within the field of trauma.
  - Joining key organisations**  
To look at building a strong pathway, help from organisations that we have links with have been key. In order to be able to have a service user led group with ongoing community options once our patients move on, we have developed strong links to the National Hearing Voices Network.

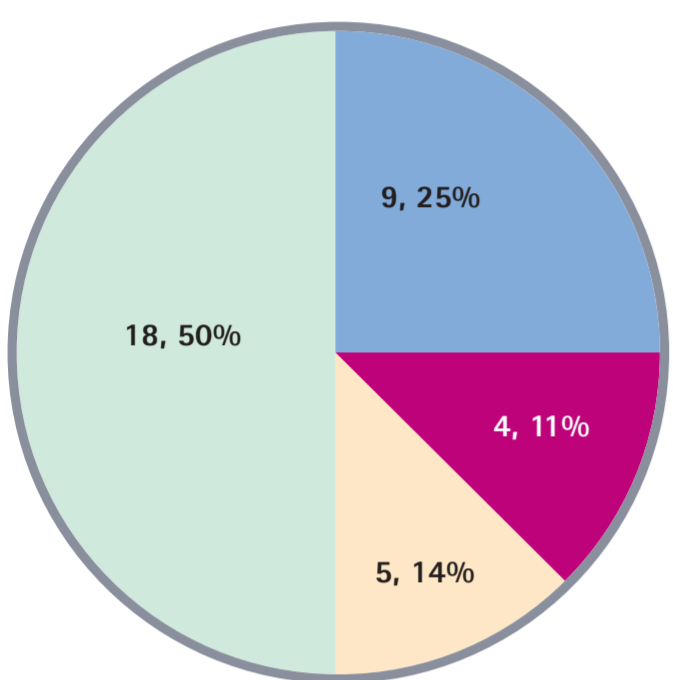
Links have been made with UK and European Trauma Group, these as identified in findings, lend us current best practice guidance and thinking in this highly prevalent area of complex PTSD within female forensic settings. We have started and continue to develop strong links with a number of universities who have known strengths working with forensic populations, this has allowed us access to all the latest journals articles and research, as well as developing research opportunities in-house.

- Utilising and enhancing existing skills base**  
There was a large existing knowledge base amongst staff, both psychological and other MDT members, as well as a large desire to be part of an inclusive therapeutic team. Therefore we have been able to offer staff training within the concepts of DBT, Schema therapy and latterly some compassionate mind work. We now have twelve trained nursing staff in key areas of substance misuse and OT staff involved with the hearing voices group and the life skills group.
- Comprehensive admission assessment utilising clinical rationale and evidence base**  
We utilised a thorough twelve week assessment psychometric battery to identify prevalence of specific symptoms and presentations, this information enabled us to tailor our interventions on an individual need basis.

## PSYCHOMETRIC ASSESSMENT FINDINGS

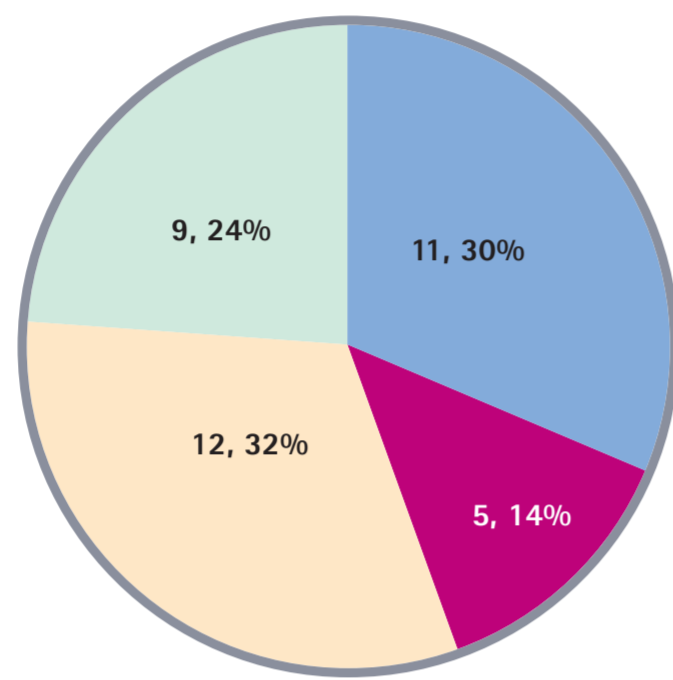
Graph i  
Beck Depression Inventory-II (BDI-II)  
(Beck, Steer & Brown, 1996)

Sample size= 36



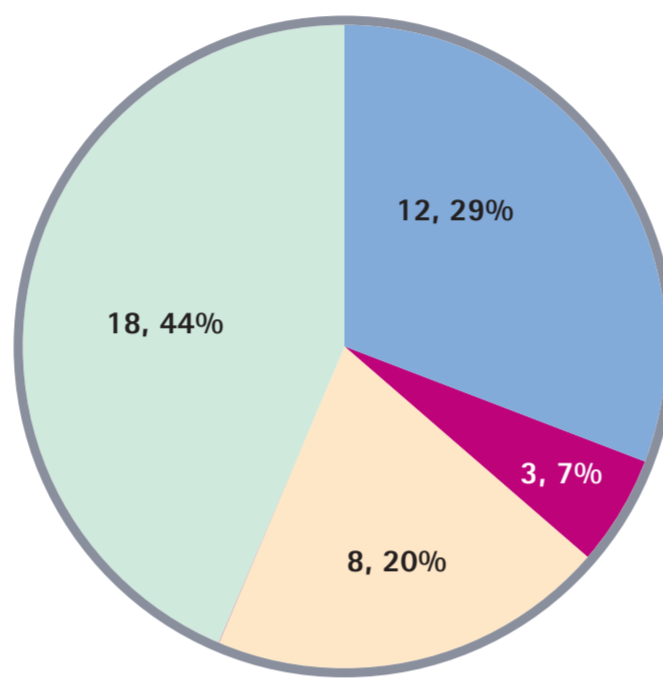
Graph ii  
Beck Hopelessness Scale (BHS)  
(Beck & Steer, 1993)

Sample size= 37



Graph iii  
Beck Anxiety Inventory  
(BAS) (Beck & Steer, 1993)

Sample size= 41

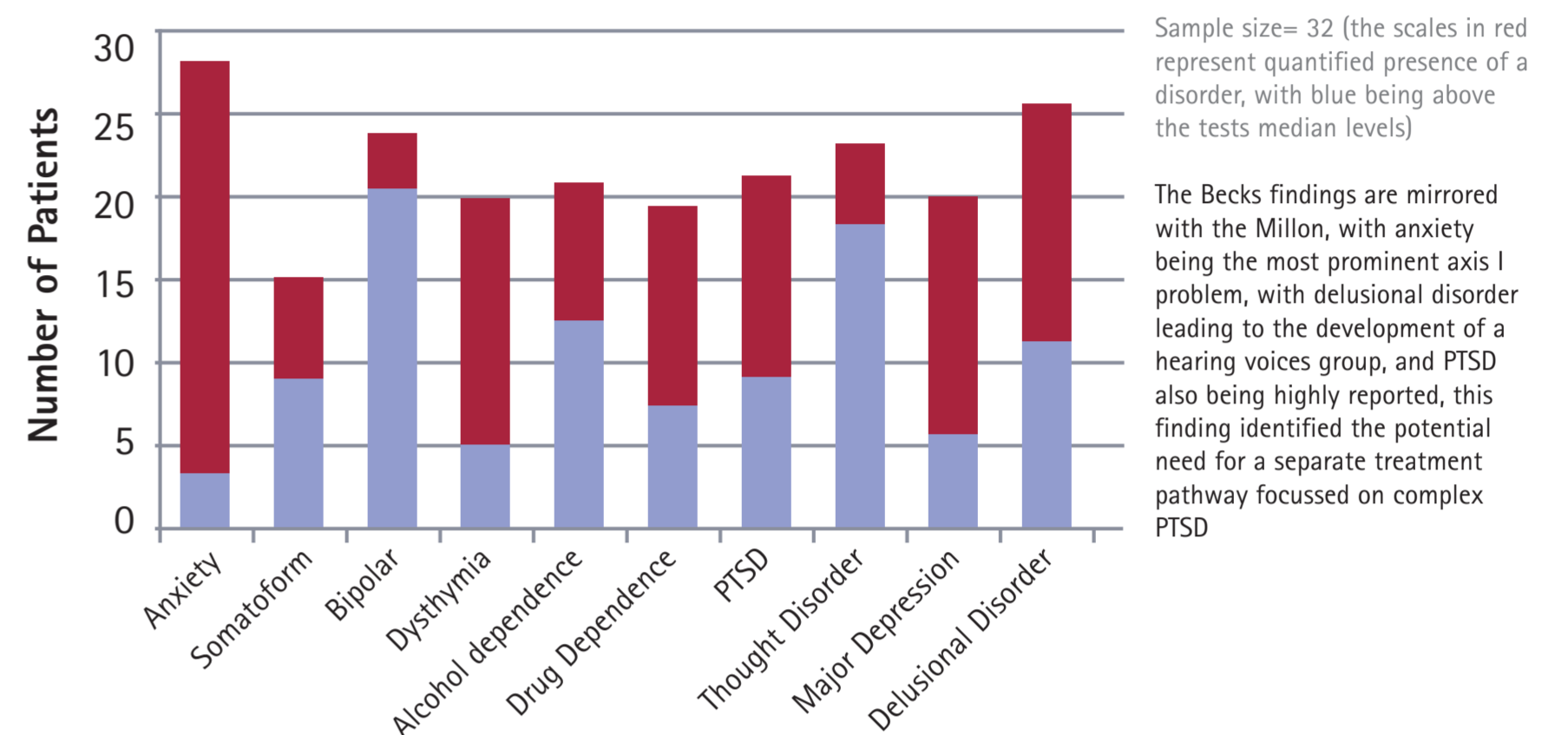


Legend: Minimal (light blue), Mild (pink), Moderate (orange), Severe (green)

As shown above the psychometric assessment found that the most problematic areas reported were depression and anxiety with hopelessness being evident but not prominent, this led to development of key groups / 1-1 focussing on emotional recognition and regulation as a treatment starting point.

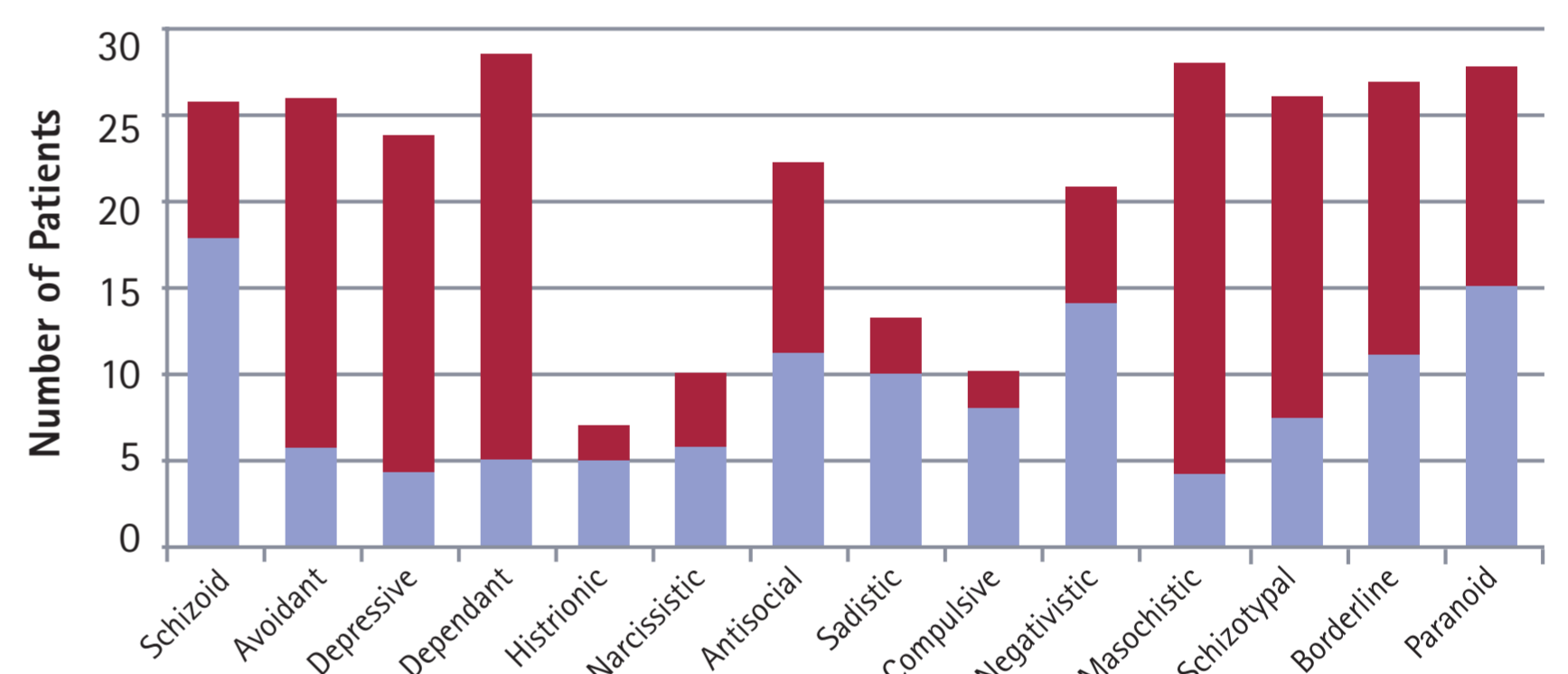
Graph iv  
Millon Clinical Multiaxial Inventory-III (MCMI-III)  
(Millon, Millon, Davis & Grossman, 1997)

### Axis I Symptomology



Graph v  
Millon Clinical Multiaxial Inventory-III (MCMI-III)  
(Millon, Millon, Davis & Grossman, 1997)

### Axis II Symptomology



The key areas most endorsed are Dependent, Borderline and Masochistic this would seem to highlight a lot of the presentation by the female population we work with, highlighting the need of therapeutic relationship to look at dependence issues and potential to polarise MDT members. This was addressed initially by identifying a primary therapist to complete the assessment battery and ongoing interventions, but also including the whole team and patient in developing and supporting the treatment pathway. We chose to look at masochistic within the internal state regarding the prevalence of self injurious behaviours we started to make sense of the presenting problems. This was then targeted via DBT skills work.

## Summary of Results:

- In women's low secure services the understanding of personality traits and their presentation can be prone to being overlooked in context of the appropriate treatment pathway and presenting behaviours
- The identification of previous trauma is paramount to any psychological intervention in order to ensure you are treating the appropriate problem
- Patients in forensic settings often have limited recognition and understanding of emotions, as such, in depth work in any area must be underpinned by increased skills in this area
- There is often a deficit in problem solving skills with this patient group which if addressed early on in a treatment pathway can lead to improved understanding and outcomes of subsequent interventions
- The need for a multi levelled individualised treatment pathway for successful treatment is essential, to ensure collaborative understanding and change

## Conclusions:

As the development and delivery of the service has progressed we have found the following:

- A need for a robust admission assessment procedure
- A collaborative working approach with patient and MDT
- A need for an individualised treatment pathway
- Working to a strict timeframe for assessment feedback formulation
- The need for a pathway by initial CPA at 12 week period
- Development and implementation of two multi tiered treatment pathways (complex trauma and non complex trauma) which is individualised to meet patient need

Figure i  
Standard Treatment Pathway

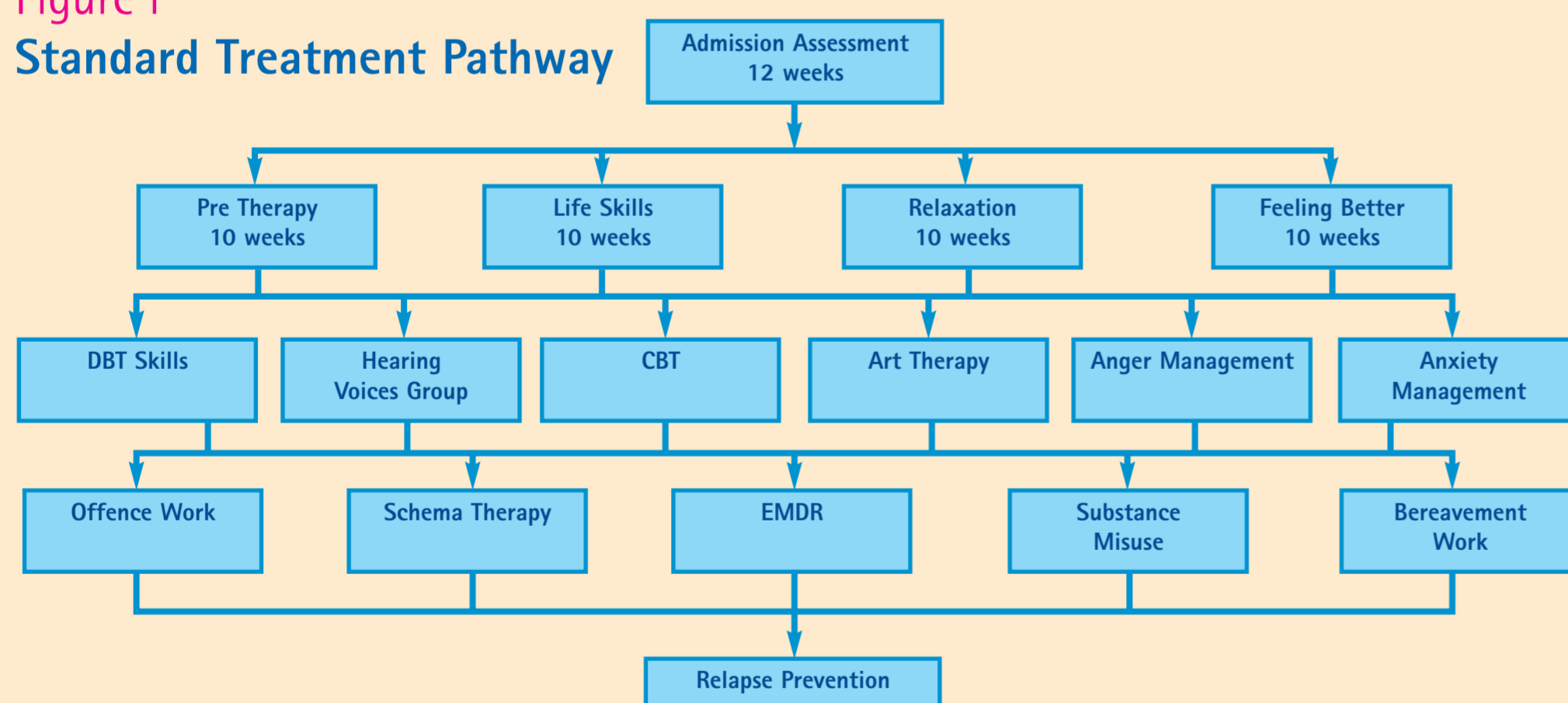
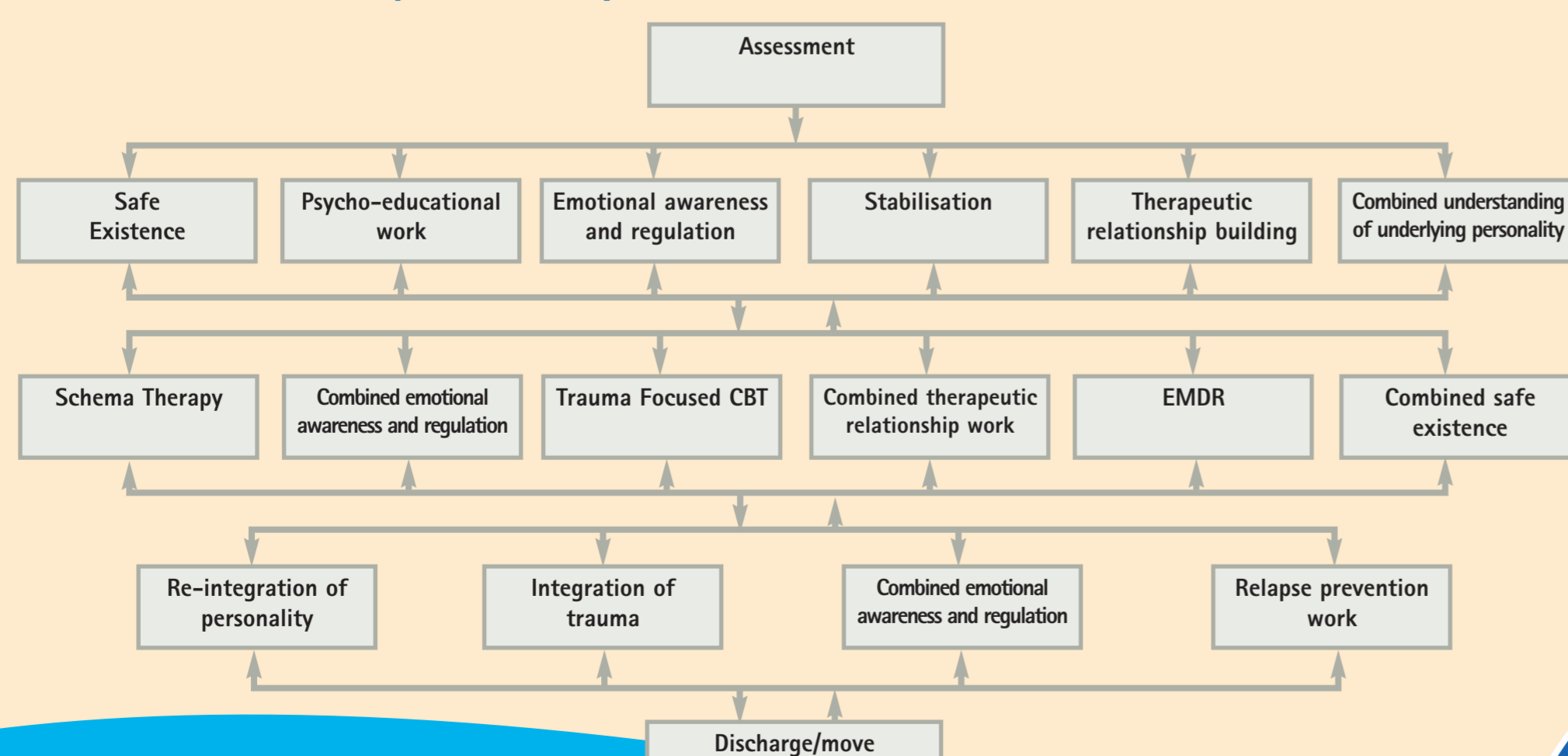


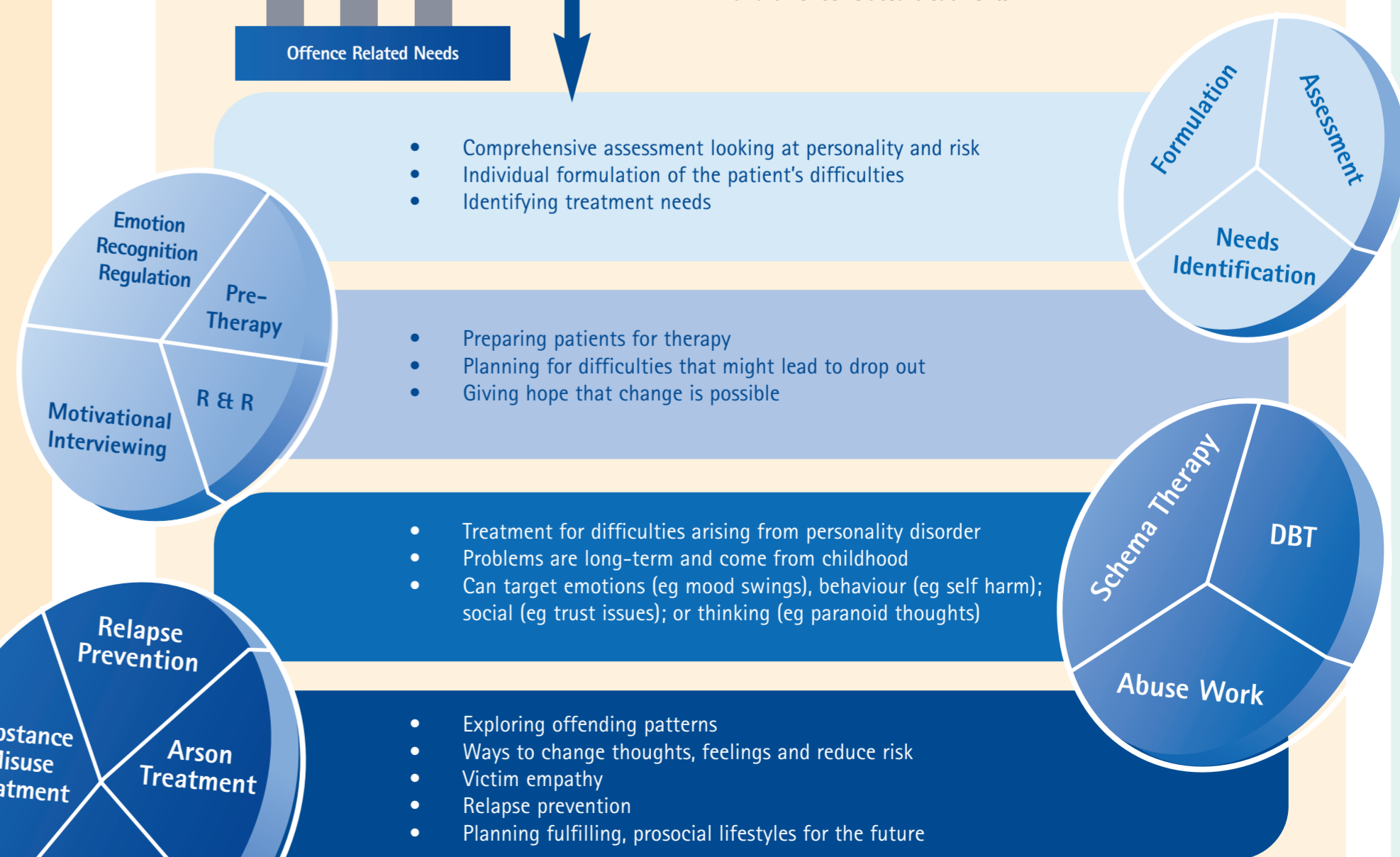
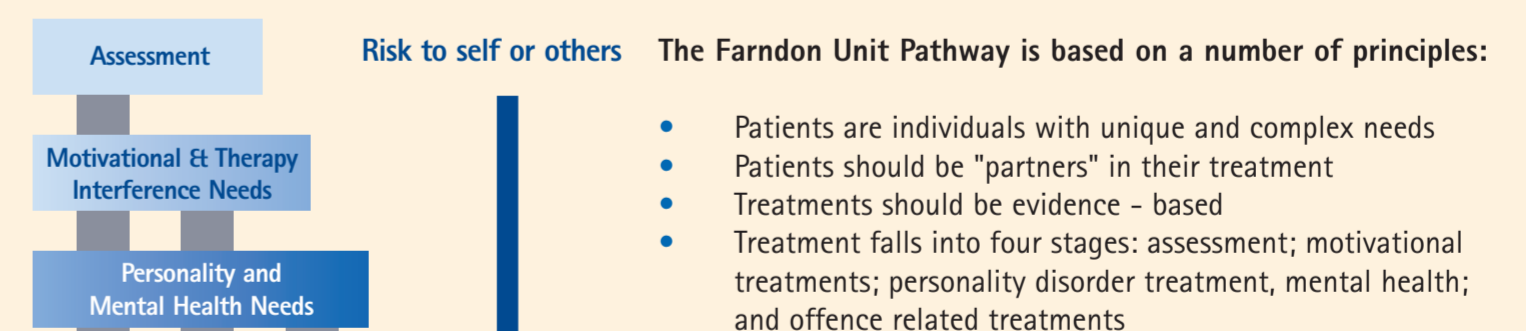
Figure ii  
Treatment Pathway For Complex PTSD



### Symptom Traits

Legend: Patients scoring between 60 and 75 (blue), Patients scoring 75 and over (red)

Figure iii Psychology Treatment Pathway



Delivering Care Without Compromise

Phil Coombes: Lead Psychologist/Deputy Clinical Director  
Sarah Dawes: Forensic Psychologist in Training