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The role and scope of forensic clinical psychology in secure unit provisions: A proposed service model for psychological therapies

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The role and scope of forensic clinical psychology in secure unit provisions: A proposed service model for psychological therapies

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Abstract

The purpose of this paper is to review the role and scope of forensic clinical psychology in forensic services and to develop a service model for psychological treatments in secure unit settings. The paper presents the findings of a one-year audit of the Southwark Forensic Psychology Service between April 2004 and March 2005, completed in order to determine the clinical activities provided by the service. It was found that 67% of working time was spent engaged in patient-related work (i.e., in direct or indirect patient contact), and an additional 11% in supervision of this work. The remainder of the time was spent in consultations and meetings, and in activities relating to recruitment, continuous professional development, research, teaching, and training. Only 19% of the patient-related work involved direct patient contact. Most of the indirect patient contact time related to attendance at management/ward rounds and care planning arrangement meetings, reading medical files, report writing, and conducting risk assessments. The audit findings have been used to produce a strength-based service model, which is based on current philosophy regarding the most effective way to integrate psychology into a multi-disciplinary team.

Keywords: Forensic services, secure units, audit, psychological therapies, patient contacts, service model

Introduction

This paper reports the findings of an audit of the Southwark Forensic Psychology Service in the Maudsley and South London NHS Trust (SLaM) between April 2004 and March 2005, conducted in order to determine the clinical activities provided by the service. Most commonly, psychology activity data are recorded in terms of face-to-face contact, but in forensic services much of the work inevitably involves indirect work with patients and
there is relatively greater emphasis on a consultative role (Young, Gudjonsson, & Terry, 2006). Thus, unless one takes account of all the key clinical activities provided, and not solely direct patient contact, the contribution of the psychology team may be underestimated and undervalued.

The second part of this paper draws on the findings from the audit to develop an organizational plan of psychological treatments in secure unit settings to maximize the effectiveness of scarce psychological resources and integrate them into a multi-disciplinary framework.

A service audit

Description of the Southwark Forensic Service

At the time of the audit period, the Southwark Forensic Psychology Service consisted of three distinct services: an inpatient service to the Denis Hill Unit and Ronnie Carr Annexe, an inpatient service to Witley 3 Ward, and a forensic outreach service based at the Maudsley Hospital. The inpatient services were based at the Bethlem Royal Hospital. Most patients had a history of violent and aggressive behaviour, severe mental illness, and high levels of co-morbidity with other problems such as personality disorder and substance misuse. There was also a high rate of borderline and mild learning disabilities.

Denis Hill Unit (DHU). The DHU is a 25-bedded medium secure unit, which provides a specialist service for the assessment and treatment of mentally disordered patients from South Southwark and Lambeth. There was a four-bedded annexe attached to the DHU for patients who required further rehabilitation in a lower security environment, but this was closed at the end of May 2006 due to financial cuts by the primary care trust. The DHU fosters a holistic, multi-disciplinary approach to care with a focus on individual patients’ needs and the provision of high quality care in a secure unit setting.

During the audit period, the DHU psychology team comprised three qualified staff: the Head of Southwark’s Forensic Psychology Service, who had four clinical sessions, two management sessions, and four academic sessions; one full-time and one half-time chartered clinical psychologist; and one full-time assistant psychologist. The Head of the Forensic Psychology Service and the half-time clinical psychologist were chartered forensic psychologists as well as clinical psychologists. In addition, during the audit period, two trainee clinical psychologists were on consecutive six-month placements working three days per week.

Witley 3 Ward (W3). W3 is a 15-bedded open forensic rehabilitation ward, which accepted admissions from maximum security, medium security,
sector services, prison, and the community. A multi-disciplinary team delivered interventions. This service was designed for the admission, assessment, and treatment of forensic patients requiring rehabilitation in an open secure facility (Young, 2006).

During the audit period the W3 psychology team comprised a full-time chartered clinical psychologist and a half-time assistant psychologist. In addition, during the audit period two trainee clinical psychologists were on consecutive six-month placements. At different times, five student psychologists worked part-time on the unit on voluntary work experience placements. Two of the students assisted with running clinical groups for patients, but most of the work of the students consisted of assisting with service-related audits.

**Forensic Outreach Service (FOS).** Southwark FOS is a tertiary-level outpatient service, based at the Maudsley Hospital. At the time of the audit the team was responsible for the care of around 30 mentally disordered offenders living in the community. This included providing a service to the South Southwark sector teams involving link-working, consultancy, risk, assessment, co-working, and individual therapy for CMHT clients perceived to be at risk of violence or sex offending.

The FOS psychology service additionally provided two clinical sessions to HMP Brixton, providing a secondary-level mental health service for prison inmates with psychiatric and psychological problems. The HMP Brixton clinical psychology service offered assessment and intervention to inmates on ordinary location in the prison or being cared for in the prison hospital wing.

During the audit period the FOS psychology team comprised a full-time chartered clinical psychologist and a half-time assistant psychologist. In addition, during the audit period two trainee clinical psychologists were on consecutive six-month placements. One student psychologist also worked at the service on a six-month undergraduate work experience placement.

**Objectives of the Southwark Forensic Clinical Psychology Service**

The main objective of the service was to assess patients’ level of functioning in different domains, determine treatment needs, and provide for these in a therapeutic approach most appropriate to the patient. The choice of treatment was informed by psychological formulation and clinical judgement. The psychology service provided was generally cognitive-behavioural in orientation, although some forensic clients can be difficult to engage in collaborative therapeutic work, and for this reason a ‘what works’ approach was often taken.

A team-based model was used on the DHU during the audit period. Here, the psychologist was attached to a specific team and provided most of
the psychology work required by that team or ward. This is the most
traditional approach and the most commonly used. It seemed to work well
within Southwark’s Forensic Service and maximized efficient communica-
tion within the multi-disciplinary team.

The primary tasks of the forensic psychology service included:

1. Clinical work:
   - psychometric assessment (e.g., admission/needs assessment, neu-
    ropsychology, personality, attitudes to treatment, attitudes to
     offending, etc.)
   - risk assessment (e.g., structured risk assessment for violence and
     sexual offending)
   - individual interventions (e.g., cognitive behavioural therapy, relapse
     prevention, anger management, substance use treatment, offence-
     focused treatment)
   - group interventions (e.g., relapse prevention for sex offenders or
     substance use, anxiety and anger management)

2. Teamwork and consultancy:
   - multi-disciplinary consultation and liaison with nurses, doctors,
     social workers, occupational therapists
   - multi-agency consultation and liaison with police, prison officers,
     probation, and other outside agencies
   - consultation and liaison with sector community mental health
     teams
   - collaboration with the North Southwark Sex Offender Treatment
     Programme

3. Attendance at meetings:
   - multi-disciplinary team meetings
   - Care Plan Approach (CPA) meetings
   - clinical governance and audit meetings
   - monthly forensic psychology meetings
   - planning and service development meetings

4. Teaching, training, and supervision:
   - training clinical disciplines in the use of actuarial risk assessment
     tools and clinical outcome measures
   - tutorials and lectures to D.Clin.Psych. trainees and M.Sc. students
     at the Institute of Psychiatry
   - clinical supervision of psychology staff, nurses conducting cognitive
     behaviour therapy (CBT), and D.Clin.Psych. trainees on placement
   - supervision of nurses and occupational therapists working on the
     DHU substance use treatment programme
   - dissemination and training to the wider clinical, forensic, and
     academic community
   - supervising audits and research
5. Management:
   - recruitment
   - management of staff and support
   - appraisals

6. Audit and research:
   - planning and conducting service-related audits
   - clinical and service-related research

Methodology

This audit was conducted by analysing records collected in the 12-month period between April 1, 2004 and March 31, 2005. Structured time sheets were completed each month by all substantive staff, trainees and voluntary members of staff (a copy of the questionnaire and the full audit report is available from the authors upon request). The questionnaire did not contain an exhaustive list of all work-related activities, but focused on the main activities. Time engaged in research was not specifically recorded, but this was restricted to one session per week for each of the clinical psychologists employed in the three separate units. All three reported that they had used their research time as allocated (this is evident from their list of research projects and publications).

Results

The results are presented under the following headings:

- summary of clinical psychology provided
- patient-related work
- supervision provided
- non-patient-related work (recruitment and meetings)
- continuing professional development, and training received
- training and teaching provided
- other activities

Summary of clinical psychology provided

Table I gives a summary of the work conducted by the Southwark Forensic Psychology Service. It can be seen that the majority of the time (78%) was spent engaged in patient-related work (i.e., in direct or indirect patient contact and supervising junior staff and/or members of the multi-disciplinary team). The remainder of the time was spent in consultations and meetings (8%), research (6%), activities relating to continuous professional development and training (6%), and providing training and teaching (2%).
Comparison between services indicates that the proportion of time spent on each of these categories was relatively consistent. However, there were some differences. The main difference related to the training and teaching provided by psychologists employed on the DHU, which was considerably lower than that provided by the psychologists working on W3 and FOS. This is partly explained by the considerable involvement of the W3 and FOS clinical psychologists in running training courses for the Southwark Forensic Service. Additionally, the two forensic/clinical psychologists who worked on the DHU had substantive academic contracts with the Department of Psychology at the Institute of Psychiatry and had honorary contracts with SLaM; training and teaching are expected as part of their contracts but, as this was an audit of the forensic clinical psychology service, their training and teaching data were excluded from this audit.

**Patient-related work**

The patient-related work provided by the forensic clinical psychology service (which took up 67% of staff time) is divided into two areas: direct patient contact and indirect patient contact. Table II provides a breakdown. This section describes in detail the direct and indirect service provision reports on the type of assessments of and treatments provided to patients.

**Direct versus indirect patient contact.** It can be seen that the forensic service spent almost four times as much time on work involving indirect patient contact as on face-to-face contact with patients. The W3 service provided
slightly less direct patient contact than the DHU and the FOS; this probably reflects the fact that the psychologist in this service took the lead in audit and service evaluation for the whole of the Southwark Forensic Psychology Service.

Direct patient contact took up 19% of the psychologists’ total patient-related work, 6% of which was spent providing individual assessments of patients and 13% of which was spent providing treatment (9% in individual and 4% in group treatment work).

The remaining 81% of the patient-related work was taken up with indirect patient contact. Out of the total amount of indirect time, the greatest amount of time related to attendance at management/ward rounds and care planning arrangement meetings (16%), report writing (15% of total patient-related work), and conducting risk assessments (14%). The risk assessments used actuarial measures such as the HCR-20, Psychopathy Checklist Revised, and/or the Risk of Sexual Violence Protocol. The planning and preparation of treatment (7%) took almost half the length of time spent delivering the treatment (group and individual treatments; 13%), most likely reflecting the sophistication and complexity of the cognitive behavioural therapy treatments provided.

Table II. Summary of patient-related work (i.e., 67% of total psychology time).

<table>
<thead>
<tr>
<th></th>
<th>DHU</th>
<th>W3</th>
<th>FOS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct patient contact</td>
<td>485 20.00</td>
<td>318 16.17</td>
<td>271 23.63</td>
<td>1074 19.39</td>
</tr>
<tr>
<td>Individual treatments</td>
<td>269 11.09</td>
<td>78  3.97</td>
<td>135 11.77</td>
<td>482  8.70</td>
</tr>
<tr>
<td>Individual assessments</td>
<td>102  4.21</td>
<td>145  7.38</td>
<td>106  9.24</td>
<td>353  6.37</td>
</tr>
<tr>
<td>Group treatments</td>
<td>114  4.70</td>
<td>95  4.83</td>
<td>30  2.62</td>
<td>239  4.32</td>
</tr>
<tr>
<td>Indirect patient contact</td>
<td>1940 80.00</td>
<td>1648 83.83</td>
<td>876 76.37</td>
<td>4464 80.61</td>
</tr>
<tr>
<td>Management/ward rounds/CPA</td>
<td>466 19.22</td>
<td>291 14.80</td>
<td>124 10.81</td>
<td>881 15.91</td>
</tr>
<tr>
<td>Report writing</td>
<td>357 14.72</td>
<td>326 16.58</td>
<td>146 12.73</td>
<td>829 14.97</td>
</tr>
<tr>
<td>Audit</td>
<td>–</td>
<td>–</td>
<td>6  0.52</td>
<td>612 11.05</td>
</tr>
<tr>
<td>Treatment planning</td>
<td>160  6.60</td>
<td>112  5.70</td>
<td>97  8.46</td>
<td>369  6.66</td>
</tr>
<tr>
<td>Patient meeting</td>
<td>294 12.12</td>
<td>19  0.97</td>
<td>–</td>
<td>313  5.95</td>
</tr>
<tr>
<td>Reading medical files</td>
<td>154  6.35</td>
<td>44  2.24</td>
<td>58  5.06</td>
<td>256  4.62</td>
</tr>
<tr>
<td>Session notes</td>
<td>121  4.99</td>
<td>32  1.63</td>
<td>41  3.57</td>
<td>194  3.50</td>
</tr>
<tr>
<td>Referrals meeting</td>
<td>58 2.39</td>
<td>29  1.48</td>
<td>77  6.71</td>
<td>164  2.96</td>
</tr>
<tr>
<td>Forensic psychology case presentations</td>
<td>33 1.36</td>
<td>19  0.97</td>
<td>21  1.83</td>
<td>73  1.32</td>
</tr>
<tr>
<td>Home visit/family intervention</td>
<td>1 0.04</td>
<td>2  0.10</td>
<td>–</td>
<td>3  0.05</td>
</tr>
<tr>
<td>Total</td>
<td>2425 100</td>
<td>1966 100</td>
<td>1147 100</td>
<td>5538 100</td>
</tr>
</tbody>
</table>
The main difference between the three units related to time spent in patient meetings, in referral meetings, and conducting risk assessments. On the DHU there was a daily patient meeting, which was attended by one or more of the psychologists. This meeting is unique to the service and took up 12% of the total patient-related work.

In the W3 psychology service, research and audit evaluation took up 31% of the indirect patient contact time. This involved detailed data collection, largely collected by students on placement for three major audit projects: the Southwark Forensic Clinical Psychology Audit (Young & Gudjonsson, 2006); the Cultural Sensitivity Audit for Southwark Forensic Mental Health Service (Young & Warnock-Parkes, 2006); and the Witley 3 Service Audit (Young, 2006).

A greater proportion of time was spent by the FOS conducting risk assessments (27%) and attending referral meetings (7%). This reflects the different needs of the different services. The FOS spent more time engaged in evaluating risk because its patients were a more direct threat to the community; thus, these risk assessments required more frequent review than required for patients detained long-term in inpatient settings.

**Assessment of patients.** The majority of the direct assessment time was spent conducting admission assessments (42%). In spring 2004, forensic psychology services introduced a standard admission assessment for patients admitted to their respective services, in order to: identify the patient’s current psychological functioning; determine future intervention needs; and provide information for use as an outcome measure. The admission assessment included an assessment of the patient’s personality, psychopathology, and attitude towards offending.

The two inpatient units spent the greatest proportion of assessment time on admission assessments (47% for DHU and 55% for W3). The outpatient service spent considerably less time on this (21%), most likely reflecting a general difficulty with engaging patients in a community forensic setting.

The second most common assessments conducted within the service were neuropsychological assessments. Considerably more of these were conducted on W3 (21%), which provided a rehabilitation service for many patients with chronic severe mental illness and cognitive impairment (Young, 2006).

Compared with the other units, the DHU spent a greater proportion of assessment time on group assessments (13%), which involved assessing patients for the substance use groups and evaluating their progress (Miles, Dutheil, Welsby, & Haider, 2007). The FOS spent a greater proportion of time assessing anxiety-related problems and substance misuse, which probably reflects the concern of the outreach team about factors which may destabilize the mental state and well-being of the patients and thereby
increase the risk of relapse and/or reoffending. Risk assessment featured relatively infrequently in face-to-face contact; this is due to the fact that the core of this work involves file-based reviews.

*Treatment of patients.* Overall, twice as much time was spent providing individual treatments than was spent providing group treatments. There was, however, considerable discrepancy between the sites, with W3 providing less individual treatment but more group treatment. The somewhat lower involvement of psychology in group treatments on the DHU is probably because this unit has a strong emphasis on individual work with patients (e.g., many patients prefer to engage in individual programmes when conducting offence-related work, which requires them to talk in detail about their offence). Nevertheless some group treatments, such as those for substance use and a patient leavers’ group, were psychology-led at this site.

*Individual treatments.* The three most common forms of individual treatment across the three services were offence-related work (14%), anxiety management (13%), and treatment for psychosis (11%).

The aim of offence-related work is to help patients develop insight into their offending behaviour. Under the model used within the service, this includes discussion and processing of the offence and/or the development of a psychological understanding of the offence. Offence-related work includes exploration of the offender’s inner world, inhibitors of offending, facilitators of offending, and the association between cognition and feeling, the development of victim empathy, and skills development (e.g., pro-social skills, problem solving techniques, and functional coping strategies). This work culminates in the development of relapse prevention and risk management plans; it also aims to reduce feelings of anxiety and stress associated with institutionalization. All of these areas are essential, leading to a reduction in the risk posed to members of the public and members of staff.

Of the individual treatments, 13% were for anxiety management. Many of the patients had been detained under section for many years – these patients, who are often institutionalized, are very anxious about taking unescorted leave in the community and require specific programmes to help them. Similarly, those near discharge or transfer to the community may feel very apprehensive at the prospect of leaving a secure and relatively protected environment for community living where they will need to engage with a new team, and find constructive daytime activities and a new social life (Main & Gudjonsson, 2005).

There were some differences between the services in terms of the individual treatments provided. The medium secure unit provided a relatively high percentage of individual treatments for psychosis (11%), focused on assisting acutely ill patients to control distress associated with delusions and hallucinations. In the community, the intervention has
greater emphasis on helping the patient to maintain a healthy mental state and prevent relapse. Patients detained on the W3 open rehabilitation ward during the period of audit were more stable and did not require this specific intervention.

Other interventions commonly provided included work on relationships, social skills, psychosexual issues, depression, substance misuse, and anger management. Again, there were differences between the three services in providing these treatments, reflecting the different needs of the patients and the setting. For example, substance misuse treatments were more commonly provided by the outreach service on an individual basis because attendance at group treatments in the community was poor.

Group treatment. Overall, one-third of all direct patient contact was taken up with group treatments. Group treatment was most common on W3 (55%), followed by DHU (30%) and FOS (18%). During the audit period an innovative substance use treatment group was developed (Miles et al., 2007). Drug use was a major problem on the DHU and associated with general behavioural problems on the unit (Main & Gudjonsson, 2006).

Supervision provided

The provision of supervision took up 11% of psychology time in total. Direct supervision was classified as formal face-to-face supervision sessions, including observation and feedback. Indirect supervision was classified as reading and correcting the reports of more junior members of staff and/or observation of assessments and treatments. Two-thirds of the supervision provided (66%) involved direct supervision and one-third involved indirect supervision (34%). Direct supervision time was predominantly provided to clinical psychology trainees (16%), assistant psychologists (15%), and qualified clinical psychologists (14%). Supervision was also provided to other members of the multi-disciplinary team, including nursing staff, occupational therapy staff, and medical staff. In particular, the FOS psychologist spent 16% of her time supervising work undertaken by forensic community psychiatric nurses. W3 had the greatest number of students working on voluntary placement, and supervision at this site was conducted as group supervision in order to make good use of time.

Non-patient-related work

Non-patient-related work took up 8% of total psychology time. In general, most time (one-quarter) was spent on matters relating to recruitment (e.g., preparation of job descriptions, short-listing and interviewing for new substantive posts, and trainee and student placement meetings). Recruitment took up 35% of DHU’s non-patient-related work and 27% of Witley
3’s. Almost all recruitment work was organized by senior psychologists at these two sites on behalf of the service.

Continuing professional development and training received

Continuing professional development (CPD) and training took up 6% of the total psychology time. From September 2005, the British Psychological Society has required clinical psychologists to submit CPD summary logs (showing a minimum of 40 hours CPD training annually) to maintain their practising certificates; thus, CPD has become an essential part of our professional work. The psychologists were spending 71% of their training time on CPD-related activities. Just under half of the total time was spent on training in the use of specialist clinical measures (40%), followed by attendance at other clinical skills lectures and/or service-related CPD activities (31%).

Mandatory training required by the Trust absorbed 22% of the total training time, and a smaller amount of time was spent on academic training (7%; e.g., training to supervise trainees).

Training and teaching provided

Training and teaching took up 2% of the total psychology time. Most training and teaching was internal (59%); there was also academic teaching to Institute of Psychiatry students (24%) and some external teaching (18%). The great majority of training and teaching related to the provision of formal training courses to Trust employees, but some training was also provided to Mental Health Act managers. The clinical psychologists employed at W3 and the FOS were trainers in risk assessment, including HCR-20 and PCL:SV, and the psychologist at W3 was additionally a trainer on the Health of the Nation Outcome Scales for use in forensic populations.

The provision of external training reflects the specialist expertise of some members of the Southwark Forensic Psychology team who, in addition to their clinical work, had made considerable developments in clinical service provision and research (Gudjonsson, Young, & Yates, 2007; Main & Gudjonsson, 2005, 2006; Miles et al., 2007; Young & Ross, 2007a, 2007b).

Main findings and recommendations from the audit

There was a high level of patient-related work, which, with supervision of staff included, took up 78% of the total time. This figure is inflated by the fact that the audit included some clinical psychology trainees and voluntary staff, whose work involved almost exclusively patient-related work. When this was taken into account, and only qualified staff were considered, it
was estimated that close to a third of their time was spent on non-patient-related work. However, this was related to the seniority of staff; more senior staff spend relatively more of their time on non-patient-related work, particularly service development, teaching and training, and contributing to audits and research, which is essential to maximize good patient care. It should also be recognized that SLaM, like other Trusts, has a number of mandatory training courses for staff, which take up a considerable amount of time.

The second important finding was that of the total amount of patient-related work, 81% was spent in indirect patient contact. This was largely due to the importance placed on regularly attending clinical multi-disciplinary meetings, liaising closely with other members of the team, and attending to continuous professional development. The team-based model used during the audit period maximized the integration of psychology services within the multi-disciplinary team and enhanced communication.

The audit identified two related ways in which to reduce the time spent on indirect patient contact. One is to reduce the amount of time spent by psychologists conducting structured risk assessments, which could be administered by other trained members of the team. A previous audit has already highlighted this as an important target for the future (Young, 2005). The second option is to integrate psychology services better into the multi-disciplinary team and develop robust group psychological interventions, particularly on inpatient units. In order to facilitate this process, the authors have developed a conceptualized framework, a service model for psychological therapies, which can be used by inpatient forensic services to guide treatments and maximize efficiency and effectiveness. The model takes into account that patients in forensic in-patient settings often have multiple and complex problems, which need to be considered when devising treatment programmes (Hodge & Renwick, 2002).

**A service model for psychological therapies**

The ‘recovery model’ (Ripper & Perkins, 2003; Roberts & Wolfson, 2004) has been advanced in the South London and Maudsley NHS Trust (SLaM) as a general model of patient care. Recovery is construed within this model as a process of personal discovery and its principles are important in any service model involving psychological therapies. The model provides a new way of thinking about mental health problems (i.e., it incorporates a service user perspective into service provisions). It offers choices to patients, builds on their preferences and strengths, and furthers self-efficacy.

There is currently no treatment service model available within the Southwark Forensic Psychology Service. Such a model would need to outline broadly the treatment options available, the processes involved in the sequencing and delivery of treatment programmes, a framework for who
delivers the different programmes, and the availability of trained and competent staff. The authors therefore developed a psychological treatment service model, which advanced the integration of forensic clinical psychology and collaboration with other disciplines, in addition to providing an organizational plan for psychological therapies that adhered to the principles of the recovery model.

**Risks, needs, and responsivity**

There are three key aspects to offender treatment (Andrews & Bonta, 1998): risk, need, and responsivity.

Risk to self and others needs to be regularly evaluated, typically using actuarial risk assessment tools such as the HCR-20 and PCL-R for violent offenders and the RSVP for sex offenders.

The treatment needs of mentally disordered offenders are complex. A number of factors need to be taken into consideration, including the nature and degree of the patient’s mental illness, cognitive factors (e.g., intellectual, memory), personality traits, any personality disorder present, maladaptive interpersonal relationships, offending factors (e.g., the nature and extent of offending, its circumstances, attitudes towards the offending, cognitive style in relation to the offending), and cultural factors.

Responsivity, which refers to the responsivity of the care provider, can be either general or specific (McMurran & Ward, 2004). General responsivity refers to the delivery of a treatment programme that is multi-modal, skills-based, and cognitive behavioural in nature (Andrews & Bonta, 1998). There is a good evidence base for the efficacy of such treatments (McGuire, 1995). Specific responsivity includes a number of factors, including matching the content and pace of the treatment with the patient’s attribution and motivation to engage in treatment.

Low motivation to change and low compliance with treatment are major problems in forensic settings (Gudjonsson et al., 2007; Young et al., 2006). McMurran and Ward (2004) provide a useful way of conceptualizing motivational problems and provide a framework and guidelines for enhancing therapeutic effectiveness. These adhere to the principles of the recovery model and should be incorporated into treatment programmes in forensic services. Gudjonsson et al. (2007) have developed instruments for identifying patients’ key perceptions and potential motivational problems, which can be used to identify potential hindrances to engagement, and to evaluate treatment outcome and changes over time.

**Risk-management model versus a strength-based model (‘good lives model’)**

The focus of a risk-management model (RMM) of offender treatment is on reducing the dynamic risk factors associated with offending, such as
criminogenic needs or dynamic attributes of offenders and their circumstances (Andrews & Bonta, 1998). These are the needs associated with recidivism and are amenable to change. Here, risk assessment is seen as essential in identifying treatment needs and it drives the treatment process. The strength of the risk-management model lies in its focus on the reduction in criminogenic needs (e.g., impulsivity, pro-offending attitudes), empirically derived principles of rehabilitation, and a range of effective treatment programmes (McMurran & Ward, 2004). Patients may also have noncriminogenic needs (e.g., anxiety and self-esteem problems), but these are seen as more discretionary intervention targets (Ward & Stewart, 2003).

In spite of the strengths of the risk-management model, McMurran and Ward (2004) have identified a number of limitations, such as its tendency to focus on risk reduction rather than positive ways of living, and its lack of attention to personal identity (i.e., the kind of life sought and the kind of person the patient would like to be) and human needs.

Ward (2002) introduced a strength-based model, labelled the ‘good lives model’ (GLM), which focuses on equipping patients with the skills or competencies required to achieve fundamental positive goals, rather than focusing exclusively on managing risk. The therapist takes a constructive approach to the patient’s overall needs, links these to the offending behaviour, attends to the patient’s current concerns, and provides the patient with realistic choices regarding goals and type of therapy. According to Ward and Stewart (2003), the focus of the GLM is on providing offenders with the necessary competencies and conditions to meet their needs (e.g., skills, values, opportunities, and social support). The GLM can be described as an enhancement model – the primary aim is not crime reduction, but improved adaptive functioning and better quality of life.

The GLM should be incorporated into psychological therapies, whether individual or group-based. This model is likely to be the most effective way of addressing patient needs, problems, and risks. In addition, it will maximize patient motivation to change. The GLM fits well within the principles of the recovery model (Ripper & Perkins, 2003).

**Organizational plan of psychological therapies**

It is essential that there is a clear overall organizational plan for the full range of treatment provisions offered to the patients. Roberts (1995) has identified three general hierarchical levels of service delivery:

- an organizational plan of the evidence-based psychological therapies available
- a clear framework for understanding the sequential order and processes involved in delivering, monitoring, and evaluating effective practice (these may be influenced by organizational and statutory requirements;
additionally, all therapy should be properly evaluated by good outcome measures

- a clear framework for the availability, knowledge, skills, and competence of staff

The service model

Figure 1 provides a proposed organizational plan of psychological therapies for forensic inpatients. It is a skills-based and need-based treatment approach, which will be multi-disciplinary, multi-modal, and integrated across different wards within forensic services. The model has been adapted from Roberts (1995), who developed it for offenders; it has been substantially modified to make it applicable to mentally disordered offenders and the anticipated needs of patients in secure unit facilities. The different treatments are presented in a sequential order based on a triangle, with an individual patient focus as the highest point and a community (rehabilitation) focus at the bottom of the provision. As patients progress through rehabilitation and recovery, they have to go through a number of layers as they move towards a community discharge (it is recognized that not all patients will be discharged directly into the

Figure 1. A skills-based service model for psychological therapies.
community, but the service model can be adapted to meet the requirements of individual patients). There are six layers in total. These layers guide the psychological therapy programmes, and provide an organizational plan of a range of treatment options which are either theoretically or empirically driven. The main theoretical underpinning in relation to the delivery of psychological services is the GLM.

The layers need not be rigidly adhered to, and are not an exhaustive list of treatment options. Each patient’s needs and circumstances should be considered within the framework of the service model, which merely acts as a guideline for the most efficient and effective service provision.

The six layers are as follows.

**Layer 1.** This is at the top of the triangle, and focuses on two important areas: first, Axis I disorders, and second, motivation and compliance with assessment and treatment.

The great majority of patients admitted to secure units have a history of major mental disorder, typically schizophrenia or schizoaffective disorder (Gudjonsson, Rabe-Hesketh, & Wilson, 1999). Acute mental illness will need to be dealt with before prosocial competencies and direct offence-related work can realistically be attempted, but some of this treatment will be psychological, combined with medical treatment (Fowler, Garety, & Kuipers, 1995). This treatment will generally be individual, but could also be group-based (e.g., psychoeducational work, voices group) or could consist of brief workshops relevant to educating patients about their mental illness. The psychological therapies offered should meet the National Institute for Clinical Excellence (NICE, 2002) guidelines about the provision of CBT for patients with schizophrenia.

Motivating a patient to comply with treatment and change needs to commence when the patient is admitted. The recommendations of McMurran and Ward (2004), within the framework of the good lives model, combined with motivational interviewing (Miller & Rollnick, 2002), will lay the foundation for such work. All disciplines should be involved, but a psychology admission assessment should form an essential part of this process.

**Layer 2.** Layer 2, prosocial competencies, is a treatment based on a social problem approach to offending (Hollin & Palmer, 2006; McGuire, 1995). The focus is on improving patients’ impulse control, reasoning (thinking) skills, understanding of the consequences of behaviour, empathy skills, interpersonal problem-solving skills, broadening their view of the world, and developing alternative interpretations of their environment, social rules, and obligations (Antonowicz, 2005).

The ‘Reasoning and Rehabilitation’ (R&R) programme is the key to the treatment offered at this layer; it has been recently adapted for use with
mentally disordered offenders (Young & Ross, 2007a, 2007b). The R&R programme does not focus directly on patients’ index or other offences. Members of the multi-disciplinary team run these groups. Psychology has an important role in the R&R programme, both in its running and in its evaluation (i.e., it will have a set of outcome measures).

Layer 3. Layer 3, offence-related therapy (ORT), is an individually-based programme that involves the identification and modification of the essential components of offending, and the development of self-efficacy and prosocial competencies that lead to reduction of risk to members of the public and staff.

ORT offers a conceptual understanding of the patient’s offending, the motivation for the offending, and the meaning of the offending to the patient (i.e., it provides a conceptual framework for understanding the patient’s offending and how to manage it).

Most of the offending will have been violent, but sexual and other offences (e.g., drug related-offences, robberies, theft) are also common among this patient group. Sexual offender treatment (Craissati, 2004; Keeling, Rose, & Beech, 2006; Marshall, Anderson, & Fernandez, 1999) should be addressed in broad terms in this layer, as a part of the ORT, but will be dealt with more specifically in Layer 4.

The ORT complements the more broadly-based R&R: it builds on what the patients have already learned from the R&R, and focuses directly on the patients’ index and other relevant offences.

Ideally, HCR-20 risk assessments (Webster, Douglas, Eaves, & Hart, 1997) should be completed prior to the Layer 3 work, and the findings incorporated into a risk management plan (Douglas, Webster, Hart, Eaves, & Ogloff, 2001), which should form a part of the ORT.

The ORT identifies and addresses factors relevant to the offending, uses depositions, including witness statements and other relevant material, to overcome denials and minimizations, while identifying the patient’s strengths and capitalizing on them. This is highly specialized individual work, which requires innovative thinking and should be guided and driven by the GLM. The ORT is based on the ways in which offenders attribute blame for their offending (Gudjonsson & Singh, 1989), their distorted cognitive style in relation to violence (Walker, 2005), and recent work into motivation for offending (Gudjonsson & Sigurdsson, 2007). These all need to be considered within the broader framework of social problem-solving and offending (Gottfredson & Hirschi, 1990; McGuire, 1995; McMurran & McGuire, 2004; Walters, 2002). The work includes the development of a relapse prevention plan (RPP), which will be refined as the patient progresses through rehabilitation and recovery towards Layer 5. Qualified clinical psychologists will typically provide this therapy. ORT will be relevant and should be applied to the majority of the patients in secure unit settings.
Layer 4. Layer 4 consists of indirect/associated focus work addressing substance use problems, trauma, anger/violence, sexual deviations, maladaptive interpersonal style, and other problems (e.g., anxiety, depression, psychotic symptoms, and obsessive compulsive problems). It will mainly be CBT orientated (Beck et al., 2004) and could use schema therapy (Young, Klosko, & Weishaar, 2003). Much of this work will be psychology-led, but the psychology input will be collaborative with other disciplines. CBT therapists, some of whom may be non-psychologists, will make their main contribution at this layer. The substance use programme set up on the DHU (Miles et al., 2007) is an example of work at this layer. Many compliance problems are associated with substance use (Main & Gudjonsson, 2006).

There is growing evidence that many forensic patients suffer from trauma-related problems, caused by childhood maltreatment (Spitzer, Chevalier, Gillner, Freyberger, & Barlow, 2006) and reactions to homicide (Curl, 1989). Spitzer et al. (2006) found that the majority of forensic inpatients had experienced severe childhood trauma, with complex PTSD being diagnosed in 28% of admissions. Young (2006) reported that during admission assessment, many of the inpatients on Witley 3 ward were reporting significant PTSD symptoms. The two most effective treatments for PTSD are trauma-focused CBT and eye movement desensitization and reprocessing (National Collaborating Centre for Mental Health, 2005). In view of the complexity of trauma-related work, this work will need to be provided by qualified clinical psychologists who have received the appropriate training.

Layer 5. Layer 5 consists of work with a specific environmental focus, and includes improving domestic, educational, occupational, and financial competencies. This work will mostly be provided by occupational therapists. Family-related work, and placement of patients after discharge, will also form an important part of the work in this layer. It can be provided by any discipline, but will largely fall within the role of social workers.

A comprehensive relapse prevention plan, focusing on mental illness, substance misuse, and offending, will be completed. This will help patients to identify high-risk situations and develop strategies to cope with them (Marlett & Gordon, 1984). In addition, R&R booster sessions will be provided to maximize the benefits of the R&R group previously attended.

Many patients experience anxieties about their discharge (Main & Gudjonsson, 2005), so leavers’ groups, along with individual therapy in some cases, should be provided. This will be psychology-led, in close collaboration with other members of the multi-disciplinary team.

Layer 6. Layer 6 involves planned discharge and re-integration into the community or another facility. Social work has an extensive role to play in
this layer. There has to be close liaison with staff that take over responsibility for the patient’s care (e.g., an outreach team) and multi-agencies (e.g., MAPPA; Young, Gudjonsson, & Needham-Bennett, 2005), and whenever possible there should be continuity of the treatment/rehabilitation programme (Mohan & Fahy, 2006).

In cases of severe personality disorder, intensive psychological therapy programmes focusing on violence reduction have been proposed and operate in some forensic services (Wong & Gordon, 2000). The proposed service model introduced in this paper is more aimed at patients with mental illness and comorbid substance use and personality disorder problems.

Conclusions

This paper addresses an important question for clinicians and service managers. How do we focus a scarce resource so that it has maximum impact on patients’ welfare?

A one-year psychology service audit showed that psychologists in the service audited spent a disproportionate amount of their time on indirect patient-related work and relatively little of their time on treatment. This is undesirable; there is a need for a radical re-think and change, with greater focus on direct patient contact and an integrated treatment approach. The findings of the audit have highlighted a number of issues relevant to practice and the contribution of psychologists in forensic services. These will need to be carefully discussed with management and service users and will hopefully stimulate other forensic services to conduct similar audits.

One of the outcomes of the audit for SLaM is that it led to the development of a comprehensive service model for psychological therapies, which has been approved by management and will be incorporated into the therapy centre in a new secure unit, River House, currently being built at the Bethlem Royal Hospital to join up the in-patient forensic services in the London boroughs of Southwark, Lambeth, and Croydon.

The audit showed that an impressive 67% of the psychologists’ time was spent engaged in patient-related work. However, close scrutiny of this patient-related work revealed that most of it (81%) was taken up by indirect patient contact, such as attending meetings about patients, preparing for assessment and therapy sessions, writing reports, and conducting risk assessments. One aim of the service should be to reduce, as far as practicable, this high amount of indirect patient contact in favour of more face-to-face contact. A complementary aim should be to develop a more systematic and integrated approach to therapy in order to maximize this face-to-face therapy contact.

The authors acknowledge that considerable indirect patient contact is essential for an effective psychology service in forensic settings. For
example, it is essential that psychologists attend and contribute to multi-disciplinary team meetings, even though these may be lengthy and time-consuming (as one would expect when discussing matters of risk and protection of the public). This ensures proper communication of the psychological perspective within the multi-disciplinary team which, in turn, will impact on any decision-making process.

The amount of time spent writing clinical reports could probably be reduced, but it is important to ensure that all relevant information is properly recorded and communicated in an efficient and meaningful way to the team and other relevant professionals. Many forensic CBT reports are long and comprehensive: they need to integrate matters of risk, and include CBT diagrammatic formulations, written material prepared and used by patients in sessions and/or used by the multi-disciplinary team, and close to discharge a detailed written relapse prevention plan.

The utility of the large amount of time spent on supervision during the audit period could be questioned, although in recent years there has been an increased recognition of the need for supervision as a professional requirement, and it typically forms a part of professional development plans. Good supervision maximizes the quality of the work of trainees and staff, provides them with guidance and support, prevents mistakes being made, and ensures that their developmental needs are met. Time could be saved where group supervision is possible.

The audit shows that risk assessment, which typically involves use of the HCR-20 and PCL-SV or PCL-R, takes up almost 14% of the indirect patient contact time. This will need to change. The problem in the Southwark Forensic Service is that although many staff from different disciplines have completed the necessary training to conduct HCR-20 risk assessments, they have been reluctant to take an active part in these assessments. As a result, it has been left to the psychologists to take the lead and ensure that such assessments are completed. In future, other disciplines should take a much more active role in conducting formal risk assessments.

The function of forensic clinical psychology is to complement the work of other disciplines. It provides a highly specialised service, which comprises a clinical interview, psychometric testing, psychosexual assessments, conceptualization of the clinical problems and offending behaviour, complex individual and group treatments, and clinical audits, evaluations, and research. Other disciplines in secure unit settings are also able to provide psychological therapies, either to individuals or groups. However, qualified clinical psychologists’ breadth of psychological skills and knowledge puts them in a better position to treat more complex cases and provide specialist offence-related treatment. The majority of patients on secure units have complex treatment needs, and will require the highly specialized skills that forensic clinical psychology has to offer. Often a variety of treatment approaches need to be incorporated into the treatment plan and many will
be based on treatment principles other than basic CBT. It is essential that there is flexibility in treatment in order to meet patients’ needs and adequately treat their problems.

The model presented in this paper is conceptualized as a series of sequential interventions, moving from a focus on the individual (management of severe mental illness, development of general prosocial competencies, direct offence-related work, etc.) to a focus on the community (development of independent living skills, discharge preparation, relapse prevention, liaison with other agencies). The focus is on treating and managing the severe mental illness, addressing criminogenic needs, improving prosocial and independent living skills, and ensuring good reintegration into a less secure environment (e.g., the community or a hostel).

In future, forensic clinical psychologists will need to prioritize their work. Their focus should be on: assessments that require psychometric testing, developing sophisticated conceptualizations and formulations of patients’ clinical and forensic-related problems, specialist treatment provisions, conducting and supervising service-related audits and research, and developing innovative and effective assessment tools and treatments. They are also likely to take on an increasingly important role in the training and supervision of other disciplines within multi-disciplinary teams.

This paper is not without its limitations. The main limitation with regard to the audit is that the psychological work within each of the three forensic services is presented as a whole. Data are not differentiated between qualified psychologists, assistant psychologists, and trainees. Each has a different role within the service and knowing their unique contribution would be of interest, although this was not an aim of the audit reported here. The second limitation relates to the proposed model of psychological therapies. It was informed in part by the results of the audit, which is a considerable strength, but the model has not yet been tested in practice or been reviewed in detail by service users. It may in due course require some refinement, but it provides a potentially useful conceptual framework for directing and operating psychological therapies.

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