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Gareth Hickman, Su Thrift, Chénelle Taylor,

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Case study illustrations of a psychological treatment pathway in a secure intellectual disability service

Gareth Hickman, Su Thrift and Chénelle Taylor

Abstract

Purpose – The purpose of this paper is to describe in detail the treatment pathway utilised in a male medium and low secure intellectual disability (ID) service. Over the preceding five years, service users have followed the outlined treatment pathway. The current paper offers case study material to illustrate the care pathway.

Design/methodology/approach – The treatment pathway is described and two case examples are provided, illustrating participation in the pathway. Evaluative data are provided on length of hospitalisation, direction of pathway at discharge and risk reduction as assessed by the HCR-20, SVR-20 and HONOS Secure measures.

Findings – The case examples provided document the assessment and treatment of two male offenders with ID, outlining their treatment pathways, subsequent reductions in assessed risk and their successful community discharge.

Originality/value – A comprehensive treatment pathway is outlined together with the theoretical rationale, with illustrative case examples.

Keywords Treatment outcome, Case study, Secure services, Intellectual disabilities, Inpatient, Treatment pathway

Paper type Case study

Gareth Hickman is based at the Secure Services, Coventry and Warwickshire Partnership NHS Trust, Birmingham, UK.

Su Thrift is based at the Brooklands Hospital, Coventry and Warwick Partnership NHS Trust, Birmingham, UK.

Chénelle Taylor is based at the Community Learning Disability, North East London NHS Foundation Trust, London, UK.

Introduction

In the UK, secure services provide healthcare treatment aimed at risk management and reduction in cases where custodial disposals are required, but prison is deemed unsuitable for the individual, in keeping with the recommendations of the HM Government (2009). This provision includes secure services for people with intellectual disabilities (ID) whose presentation requires ongoing detention and cannot be safely managed in the community (Alexander *et al.*, 2011). Individuals within secure services are predominantly detained under sections of the Legislation.gov.uk (2018), most commonly the criminal sections of the Mental Health Act, due to their ongoing risk of offending or risk behaviour.

Given that the primary aim of secure services is to reduce risk of offending, the question of the effectiveness of treatment approaches at reducing risk is inevitably pertinent. However, with no commonly agreed outcome measures with which to evaluate service impact and treatment outcome, this can be challenging. Alexander *et al.* (2011) highlight a small number of studies that relate specifically to service-level outcomes at the point of discharge from high, medium and low secure ID services (Reed *et al.*, 2004; Day, 1988; Halstead *et al.*, 2001; Alexander *et al.*, 2006; Gray *et al.*, 2007; Butwell *et al.*, 2000; Morrissey *et al.*, 2007). The core outcome measures utilised in these studies were duration of stay, direction of care pathway, hospital re-admission, institutional aggression and re-offending behaviour. In summary, this literature highlights a number of limitations with these evaluation approaches. For example, average duration of stay is a difficult construct to meaningfully measure (Butwell, 2003), and dependent on what inclusion/exclusion criteria (e.g. high/medium/low secure patients; males and/or females; remanded

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patients; deaths; treatment phase or total detention) and measurement methods (e.g. mean, median length of stay) are used in audits, the range of hospitalisation duration varies.

Additionally, direction of care pathway in regard to level of security appears to be a more effective evaluative criterion only if long-term follow-up data are provided, rather than only initial discharge destination. This can create a misleading picture of positive progress as, without follow-up data on reconvictions and re-offending, it is difficult to draw conclusions regarding sustained treatment gains. However, follow-up data such as re-offending and reconviction rates alone can also be unreliable measures of treatment pathway effectiveness for a number of reasons. This includes the fact that studies are less likely to report on offending-like behaviour that does not result in convictions (Alexander *et al.*, 2006). Reconviction data, by its nature, only relate to instances where offenders have been apprehended, and also a large number of offenders with ID are discharged to highly supported/supervised conditions, making it difficult to discern between treatment effect and supervision effect.

Morrissey *et al.* (2014) examined outcomes in terms of change in risk scores on the HCR-20 violence risk assessment (Douglas *et al.*, 2013) in a High Secure setting. In this context, it was concluded that there was a significant group of service users for whom risk scores did not change and that the trajectory of male offenders with ID was less positive than that of non-ID offenders in High Secure settings. Morrissey *et al.* (2015) offered a review of the service-level outcomes from the National High Secure Learning Disability Service. In addition to the more commonly reported measures outlined above, they report on patient-based outcome measures using the emotion problem scale and behaviour rating scale self-report inventories. They conclude that, on staff-rated global clinical measures, there did not appear to be a treatment effect over two or three years. However, patient self-report measures of externalising problems (e.g. aggression, non-compliance) and internalising problems (e.g. depression, anxiety, low self-esteem) did show improvement.

A notable recent contribution to this literature is offered by Morrissey *et al.* (2017). This study offers a comprehensive review of the literature in this area and seeks to identify the domains that should be used to measure outcomes for people with ID and forensic needs. The authors provide a systematic review of 60 studies and then offer a framework, co-developed through consultation with service users, carers and experts, consisting of three outcome domains: effectiveness, patient safety and patient and carer experience. Of relevance to the current study, the effectiveness domain of the framework includes, amongst other categories, discharge outcome/direction of care pathway, length of hospital stay, clinical symptom severity, risk assessment measures and security need. It is of note that Morrissey *et al.* (2017) highlight of the 60 studies reviewed, only one (Alexander *et al.*, 2011) described in the nature of the treatment programme that is delivered within the service.

Without reporting specifically on the treatment pathway followed by the service users involved, or offering transparent details of the interventions provided, it makes it difficult to draw conclusions about the mechanisms of change involved in the existing published studies. The exception to this is Alexander *et al.* (2011), who outline a ten-point treatment programme from initial assessment through to preparation for transition, encompassing formulation, risk assessment, pharmacotherapy, individual and group intervention, care planning, offence-specific intervention and educational and vocational skills. This care and treatment pathway represents a multi-disciplinary pathway and details the essential steps in the care of these service users, consistent with previous care pathway definitions (e.g. Buxton *et al.*, 2004).

The current paper sets out to add to the literature by describing in detail the treatment pathway utilised in the Brooklands secure service and illustrating this pathway approach through two case study examples. The treatment pathway framework outlined represents the psychosocial intervention components of a larger multi-disciplinary pathway which includes risk management, improving service users' physical and mental health, ensuring meaningful occupation and activity and family and carer involvement. The secure service at Brooklands, provided by Coventry and Warwickshire Partnership NHS Trust, consists of medium and low secure facilities for adults with ID. The service provides four wards, one medium secure unit (MSU of 15 male beds), 26 male low secure unit (LSU) beds over two wards and one female LSU of 15 beds, comprising a total of 56 secure beds.

Service developments in 2011 led to a restructure of the treatment pathway within the male secure service led by the Lead Psychologist (Thrift, 2011), which came online in 2012. Over the last five years, service users within the men's secure service have followed the treatment pathway outlined here.

Psychological treatment pathway

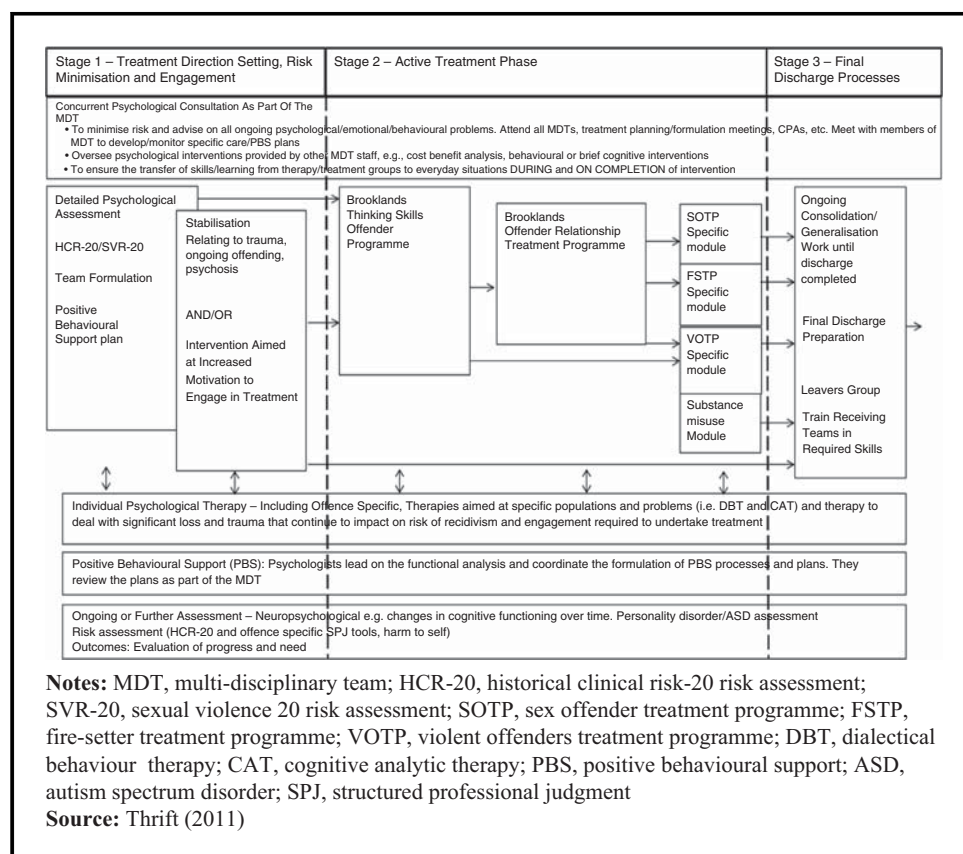
The rationale for the pathway redesign in 2011 was influenced by a range of factors. These included internal service audits and evaluations that indicated changed service user need in relation to type of offences that some psychosocial deficits were not adequately addressed in the current pathway and a preferential order in which to undertake the treatment programmes to ensure maximum treatment gains. In addition, the redesign was cognisant of government publications such as Department of Health (2010), where on-going efforts to reduce the duration of hospital detention, subsequently highlighted by the Transforming Care Agenda, and Positive and Proactive Care and reducing the need for restrictive interventions (2014), have been the focus. Further drivers to pathway redesign included commissioning and contractual arrangements and expectations as specified through NHS key performance indicators, Commissioning for Quality and Innovation schemes, Service Contracts and Care and Treatment Reviews.

The structure of the current pathway is displayed in Figure 1 and outlined further below. A simplified service user accessible version of this pathway personalised to individuals' treatment pathway is provided to service users where appropriate.

Initial assessment (maximum 12 weeks duration)

The Psychological Admission Assessment aims to identify psychological factors that have contributed to the development and maintenance of the individual's offending behaviour and how

Figure 1 Treatment pathway



these inter-relate; as informed by the psychological evidence base about specific offence type and other presenting difficulties. Recommendations are then made as to the most appropriate and efficient psychological treatment pathway to reduce the risk of the individual re-offending to the point that they could be discharged, and to improve their psychological functioning generally, for example, in relation to trauma, personality disorder or psychosis. The assessment also considers factors that are likely to adversely affect the individual's engagement with recommended or available treatment options and how to address these to maximise engagement. Finally it looks at ongoing interactional difficulties or risks presented and work required to address these.

Formulation

A case conceptualisation and risk formulation is developed from the assessment data identifying personal and contextual factors pertinent to the individual's risk and offers treatment recommendations. Routinely, this involves team formulation approaches (see Johnstone and Dallos, 2013).

Stabilisation, engagement and motivation

This initial stage of engagement and motivation development is consistent with concepts of pre-therapy (e.g. Prouty *et al.*, 2002). The duration of this is dependent on need. These initial three phases outlined have an inevitable overlap and are not necessarily experienced as discrete phases.

Cognitive enhancement intervention (10–12 months approximate duration)

Cognitive deficits are demonstrably linked to recidivism in offenders (e.g. Porporino and Fabiano, 2000; Friendship *et al.*, 2003). Cognitive enhancement programmes have been shown to reduce recidivism risk in ID offenders (e.g. Waugh *et al.*, 2014; Kelly, 2014; Lindsay *et al.*, 2011). The Brooklands Thinking Skills Offender Programme (BTSOP), which addresses such deficits, frequently represents the first episode of therapeutic intervention experienced by service users with the psychological treatment pathway. The BTSOP has been shown to produce significant improvements in social and interpersonal problem solving (Hickman *et al.*, 2017).

Relational intervention (9 months approximate duration)

An association between early attachment experiences and offending behaviour has been demonstrated (e.g. McCormack *et al.*, 2002), particularly the association between poor early attachments and later sexual offending (Maniglio, 2012; Marshall, 2010). An internal service audit (Thrift, 2011) identified that 66 per cent of male service users of the preceding five years, had assessed relationship/interactional and attachment deficits. This led to the development of the cognitive analytical therapy informed Brooklands Relationships Offender Treatment Programme (BORTP) (Murphy, 2014). This became an identified second stage in the pathway, where there was an assessed need, particularly in relation to the treatment of sexual offenders.

Offence-specific intervention

Core risk interventions offered include programmes for sexual offending, violence and aggression and fire-setting. These programmes are provided on a group basis or individual basis. These interventions combine cognitive behavioural therapy (CBT) strategies with a Good Lives Model (Ward, 2002) based approach. Each programme has an approximate duration of twelve months, although this may vary when completed individually.

Individual psychological therapies

It is common for service users to complete some aspects of treatment in groups and then some aspects individually. Significant numbers of service users at Brooklands Hospital have a range of comorbid mental health difficulties, trauma histories, personality disorders and/or autistic spectrum disorders. Psychological intervention is provided individually when the person's needs are more suited to this modality of therapy. This may be because they have presentations unsuited to group

work (e.g. autistic spectrum disorder in some instances, ongoing risk of violence in group settings, etc.) or the nature of the presenting psychological problem is unique to them. If there are not enough patients with similar presentations to develop a group, then psychological therapy is undertaken individually with the person to ensure no extension to length of stay. In some cases, such as DBT, patients will receive individual and group therapy concurrently.

Substance misuse programme

Chaplin *et al.* (2011) estimates that 15 per cent of ID offenders in hospital have a history of substance misuse problems. Indeed, Thrift (2011) identified that 33–50 per cent of secure service users in the previous five years had had substance misuse problems. The substance misuse programme is offered over three stages; an initial psychoeducation approach focussing on substance awareness; a formulation based brief intervention highlighting core risks associated with substance misuse; a comprehensive formulation based group intervention using a CBT model focussing on relapse prevention. Due to the role substance use frequently plays in offending risk, this work is often conducted in parallel with other interventions in order to link associated concepts.

Positive behavioural support

Positive behavioural support (PBS), as advocated by the Department of Health (2014) guidance framework and the 2015 Code of Practice the Legislation.gov.uk (2018), is a multi-element framework within which an understanding of the function of behaviours of concern and a support plan outlining the best ways to work with a specific individual to decrease behaviours of concern are developed (Gore *et al.*, 2013). This plan also seeks to improve the individual's quality of life, including increased community presence. All service users within the Brooklands inpatient settings have a PBS plan. This is developed by the MDT, with the psychologists in each team ensuring this is based on a data-driven analysis of the functioning of behaviours and presenting difficulties.

Consolidation

It is commonly recognised that people with ID undertaking therapy benefit from support to generalise the learning and skills from therapy room to real-life situations. This support is provided throughout the pathway at Brooklands by the nursing teams reinforcing learning and skills use and in individual sessions with members of the Offender Group Treatment Team (OGTT). Training is provided to the nursing team regarding this essential role. This support is adapted as service users progress along the pathway to reflect the shift from external to self-management that is expected, and is provided until discharge.

Exit preparation

Preparation for future transition from hospital is provided both on an individual basis and offered as a recovery-based group intervention. The duration of the group intervention is eight weeks (Hickman *et al.*, 2018).

As previously noted these psychosocial components are part of a comprehensive multi-disciplinary pathway aimed at risk reduction, health improvement and skill development in order for the person to move to conditions of lesser security as quickly and safely as possible.

Method

The current paper aims to illustrate the outlined treatment pathway approach using the following case examples.

Case example 1: individual who has followed the pathway in full, involving a series of offender group interventions.

Case example 2: individual who has completed a treatment pathway that involved a mix of offender group and individual interventions.

Consent: service users provided their informed consent to the inclusion of case material in the examples provided. These are fully anonymised and certain key identifying details have been altered to preserve anonymity.

Assessment measures

Each specific intervention along the treatment pathway is evaluated with relevant outcome measures (e.g. see Hickman *et al.*, 2017), however, in order to assess the effectiveness of the treatment pathway in regard to risk reduction overall, data from admission to the end of the treatment pathway were collected from clinical records for the following measures.

HCR-20 (historical clinical risk-20) (Douglas et al., 2013). The HCR-20 provides a standardised schedule for the assessment of risk of future violence. The HCR-20 is completed every six months as a minimum standard. Risk factors are coded as either "Yes, Definitely Present", "Possibly/Partially Present", or "No, Absent". As the HCR-20 V3 does not yield a total risk score, the number of each of these factors was established at each administration. Therefore, reductions in the number of present or partially present risk items and increases in the number of absent risk items can be considered to represent risk reduction.

SVR-20 (sexual violence risk-20) (Boer et al., 1998). The SVR-20 is a 20-item checklist of risk factors for sexual violence. It is completed every six months as a minimum standard within Brooklands secure services for those who have committed sexual offences. Items are coded as either "Yes Present", "Possibly/Partially Present", or "Not present". This measure does not yield a total risk score, therefore risk reduction is assessed as described above.

HoNOS Secure 2b (Health of the Nation Outcome Scales) (Sugarman and Walker, 2007). This tool is specifically designed for use in health and social care settings such as secure psychiatric, prison health care and related forensic services. The completed HoNOS secure provides a profile of 19 severity ratings, a total HoNOS Clinical Score, and a separate Security Score. It is intended to be an integral part of a minimum data set and a basic component of the Care Programme Approach for users of secure services and is completed on a six monthly basis. Therefore reductions in the Clinical and Secure Scale Scores can be considered to represent risk reduction.

Case Illustrations

Case example 1

Mr A is a 27 year old, Caucasian male with a conviction for sexual offences against a child. He has a diagnosed mild ID (Full-Scale Intelligence Quotient 63). Mr A's mother is reported to have had a diagnosis of ID. His father was alcoholic and was frequently violent to his mother in the presence of Mr A. His parents separated when he was seven years of age and his mother left the family home leaving Mr A in the care of his father. Soon after, Mr A was removed from his father and placed in Local Authority Care following concerns of neglect and alleged sexual abuse in the family. After a period of eight years, Mr A left care and returned to his mother and step-father. Mr A has not maintained consistent employment and has no formal qualifications. Mr A identifies himself as heterosexual, although he has had no significant intimate relationships. He has had no significant non-intimate relationships and following his Index Offence has no contact with his family.

Mr A was convicted of two counts of rape of a female under the age of 16. The victim was his 12 year old cousin. Mr A pleaded guilty and was subsequently placed on Section 37/41 of the Mental Health (1983/2007) Act and was admitted to Low secure services for treatment.

Following admission, Mr A completed a Psychological Admission Assessment as part of the multi-professional assessment phase of his treatment pathway. Assessment indicated a pattern of impulsivity, distorted attitudes towards women and children, limited insight and social support, as well as anxiety surrounding relationships and social and interpersonal deficits. It was considered that these deficits related to his ID and traumatic early life experiences, with reduced ability to develop and employ coping strategies. His main identified risk involved unsupervised access to minors. A team formulation was constructed, leading to an outlined intervention pathway. A comprehensive

Positive Behaviour Support plan was established in collaboration with Mr A. It was recommended that he engage in the Thinking Skills Programme (BTSOP) to address his impulsivity and enhance social and interpersonal problem solving skills. Following this, Mr A completed the Relationships Programme (BORTP), geared towards helping him gain insight into his interactional difficulties that were associated with his offending and specifically to understand social and legal boundaries within relationships. He then completed the Sex Offender Treatment Programme (BSOTP) to address the attitudes and cognitions that led his offences, building an understanding of his offence pattern and identifying relevant risk reduction strategies. At the end of this treatment pathway, Mr A was able to identify high risk, thoughts, feelings and situations that were predictive of offending behaviour, and unhealthy reciprocal roles in his relationships. He was also observed to be more open about his sexual attraction to adolescents, and demonstrated increased awareness and insight into his cognitive distortions and wider risks. Mr A was also able to access unescorted community leave in the local area. Finally, Mr A attended a Leavers' Group, aimed at comprehensive preparation for discharge.

In addition to a range of pre and post treatment outcome measures (undertaken in relation to each group or individual therapy) and continuous clinical observation, Mr A's level of risk was assessed using HCR-20, SVR-20 and HoNOS Secure. Table I illustrates his risk scores over the course of his treatment pathway. Mr A's "present" risk factors decreased, while his "absent" risk factors increased. The SVR-20 data indicate that present risk factors showed a small decrease, with small increases in the number of "possible/partial" factors. The "absent" risk factors remained stable. HoNOS data show a notable reduction on the Security Scale and a stable but small post treatment increase on the Clinical Scale.

At the end of Mr A's treatment pathway his risk was considered to have reduced sufficiently for him to be conditionally discharged to a supported community residence, with a care package of 12 h daily 1:1 support, with 24 h access to staff support if required. Total hospital admission duration: 50 months.

Case example 2

Mr B is a 42 year old, Black-British male with convictions for sexual offences against children. Following a brief detainment in prison, he was transferred to the specialist Secure Service under section 37 of the Legislation.gov.uk (2018), due to the identified presence of mild ID (Full-Scale Intelligence Quotient 61). Mr B has a history of significant health problems and has experienced bullying and physical abuse including one episode of sexual abuse during his childhood. He has not maintained consistent employment and has no formal qualifications. Mr B identifies himself as bisexual although has had no significant intimate relationships. He has had no significant non-intimate relationships outside of his immediate family.

Table I Case example 1 outcome data summary

	Number of present risk factors	Number of partially present risk factors	Number of absent risk factors	Number of omitted risk factors
<i>HCR-20</i>				
Pre	8	3	9	–
Mid	7	4	9	–
Post	6	3	11	–
<i>SVR-20</i>				
Pre	6	1	13	1
Mid	5	2	13	1
Post	5	2	13	1
	Security scale		Clinical scale	
<i>HONOS: secure</i>				
Pre	14		6	
Mid	14		7	
Post	11		7	

At 20 years of age, Mr B was convicted for a sexual assault against a male under the age of 16, which involved inappropriate touching; subsequently he was placed on probation after pleading guilty. Mr B was again convicted for assault against a male under the age of 16, when he was 30 years old and again received probation for this offence. Mr B's Index Offence was a retrospective conviction for a further sexual assault of a male under the age of 16, committed in the late 1990s.

Following his admission, Mr B engaged in the Psychological Admission Assessment as part of the multi-professional assessment phase of his treatment pathway. Assessment indicated a pattern of distorted attitudes towards children, limited insight, low self-esteem and high levels of shame and passivity, as well as anxiety surrounding relationships and uncertainty regarding his sexual preferences. He also had difficulties developing age appropriate relationships. It was considered that these difficulties and deficits related to his ID and traumatic early life experiences. His main identified risk involved unsupervised access to children. A team formulation was constructed, leading to an outlined intervention pathway. From the outset, a comprehensive PBS plan was established in collaboration with Mr B with input from his family members, who remained supportive. On admission, Mr B presented as highly anxious about participating in treatment. As such, he participated in an episode of individual intervention addressing these areas. It was then recommended that Mr B engage in the Thinking Skills Programme (BTSOP) to address his emotional literacy deficits and enhance his social problem solving skills. Following this, Mr B completed the Relationships Programme (BORTP), geared towards helping him gain insight into his interactional difficulties associated with his offending. Following this intervention, Mr B showed marked anxiety about participating in offence-specific intervention; as such he completed a further brief piece of individual anxiety management in preparation for the next group. He then completed the Sex Offender Programme (SOTP) to address the attitudes and cognitions that led his offences, building an understanding of his offence patterns and identifying relevant risk reduction strategies.

Upon completion of these interventions, Mr B demonstrated improvements in his ability to identify high risk, thoughts, feelings and situations that were predictive of offending behaviour and developed a range of risk management strategies. He was also observed to be less passive and to develop skills in assertiveness. He was also able to develop some prosocial peer relationships. Mr B was also able to access unescorted community leave in the local area. Finally, Mr B attended a Leavers' Group, aimed at comprehensive preparation for discharge.

Table II illustrates Mr B's HCR-20, SVR-20 and HoNOS scores over the course of his treatment pathway. Mr B's "present" risk remained stable, whilst the "partially present" factors reduced. The number of "absent" risk factors increased. The SVR-20 data indicate that "present" risk factors remained stable, with small increases in the number of "absent" risk factors and small decreases in the number of "possible/partial" factors. HoNOS data indicate small reductions on the Security Scale and small increases on the Clinical Scale.

Table II	Case example 2 outcome data summary			
	Number of present risk factors	Number of partially present risk factors	Number of absent risk factors	Number of omitted risk factors
<i>HCR-20</i>				
Pre	5	6	9	–
Mid	5	5	10	–
Post	5	3	12	–
<i>SVR-20</i>				
Pre	5	1	13	1
Mid	5	2	13	–
Post	5	0	15	–
	Security scale		Clinical scale	
<i>HONOS: secure</i>				
Pre	13		1	
Mid	11		3	
Post	12		5	

On completion of Mr B's treatment pathway his risk was considered to have reduced sufficiently for him to be discharged on a Guardianship Order to a supported-living community residence, with a care package of 8 h daily 1:1 support, with 24 h access to staff support if required. Total hospital admission duration: 60 months.

Discussion

The current paper outlines a treatment pathway model used in a men's ID medium and low secure service and provides illustrative case examples. This addition to the literature offers increased transparency in outlining a model, and its rationale, for delivering risk reduction interventions in this area of service provision. The case studies highlight the individualised nature of the pathway and, although these represent only a snapshot of current practice, they demonstrate how a pathway model can create clarity whilst also being applied flexibly to each individual's needs and lead to effective risk reduction.

Whilst the case study illustrations provide idiographic examples of the treatment pathway experience, a number of notable points can be drawn from them. Previous studies examining duration of hospitalisation in medium and low secure services have reported median length of stays of 2.3–2.8 years with some hospitalisations in excess of five years (e.g. Halstead *et al.*, 2001; Alexander *et al.*, 2011). The current case examples are in-keeping with these time frames.

Both case examples demonstrate risk reduction and discharge. Such community discharge is only possible through demonstrable risk reduction. In practice, assessment of risk is done through a multi-modal approach, including structured risk assessment, clinical and behavioural observation, participation and engagement, psychometric assessment, community access, multi-disciplinary review, and the inherent safeguards of the Mental Health Act and Parole Systems. The HCR-20, SVR-20 and HoNOS data presented are in supplement to an additional comprehensive range of risk assessment, however, are offered here as illustrations of the whole pathway effect. It is recognised that these tools can be limited in their application and may be limited in their sensitivity to highlighting many of the subtle but significant internal and external changes that service users make throughout their treatment. Both the HCR-20 and SVR-20, for example, have a high number of static variables that would not be expected to reduce even following effective treatment.

Strengths and considerations

Reflecting on the strengths and potential limitations of this pathway approach the following areas are highlighted. Engagement within this pathway is formulation led from the outset and therefore the service user's journey is MDT informed, based on psychological evidence base and individually tailored to address their identified risks. Particular modules of specific interventions can be completed or omitted as required.

Importantly, the visual schematic permits service users to understand and recognise where they are in the process and provides a sense of progression and potential end point to work towards. Whilst progression through to completion of the pathway does not guarantee discharge, this model does provide some sense of a map of the terrain they are navigating insofar as is possible and can be reassuring, motivating and protective against hopelessness and anxiety.

Strength of this approach is the cumulative nature of the interventions. As shown in Figure 1, the BTSOP frequently represents the first episode of therapeutic intervention experienced by service users; the subsequent intervention programmes that follow seek to build upon the foundations and concepts covered. A number of core components are carried through into further treatments, such as emotional literacy (i.e. thought-feeling-action sequences, emotional awareness, recognition and regulation), managing impulsivity, cognitive flexibility, social perspective taking, evaluating decisions, implementing actions and reflection. Deficits in these areas have been shown to be linked to recidivism in offenders (e.g. Porporino and Fabiano, 2000; Friendship *et al.*, 2003). By preventing repetition and implementing incremental learning the ultimate length of subsequent interventions can be reduced as new concepts do

not need to be introduced in offence-specific intervention. Moreover, as the BTSOP is a non-offence-specific programme it can be accessed by service users with different offences meaning that individuals are not delayed in commencing their treatment as they wait for the formation of offence-specific groups. In this regard, the BTSOP has similarity to a unified transdiagnostic protocol (Barlow *et al.*, 2011) in teaching core skills that can be applied across different risk/diagnostic profiles. This also makes such an approach accessible to smaller service providers where service user numbers are insufficient to consistently run offence-specific groups.

There are some potential limitations of this pathway approach. First, it may be considered that this approach is prescriptive and offers a fixed series of interventions that a service user must complete. However as highlighted, an individual's personal pathway is formulation led at all stages and the framework allows for individually tailored treatment throughout. Indeed it would be possible to complete all intervention on an individual basis if need indicated. Second, given that each of the core interventions (BTSOP, BORTP, Offence Specific) has an approximate 9–12 month duration, one could expect an approximate complete-pathway duration of three years. To expedite discharge and reduce hospitalisation these interventions are consistently reviewed to reduce their maximum duration and this work continues actively.

A third consideration is that offence-specific intervention occurs following cognitive enhancement and relational interventions, leading to the possibility of identifying previously unknown risk factors towards the end of the pathway. The model, however, has the inbuilt safeguard that, throughout non-offence-specific interventions, individual sessions linking the content to offence accounts take place. There is also the possibility of completing further individual work where required after offence-specific intervention. Indeed, it is considered that the BTSOP and BORTP provide the necessary distress tolerance, coping skills and understanding required to manage the challenging content of offence-specific intervention.

Practical considerations

Each of the offender group interventions is co-delivered by the OGTT. Facilitator teams include clinical psychologists, nurses and specially trained health care assistants. Supervision is provided by a consultant or principal clinical psychologist. The role of a dedicated team with protected time is instrumental to the delivery of these interventions and is a critical consideration when applying this pathway approach. Their role in training staff and transfer of learning from group room to use in real-life situations is also invaluable as noted above.

Following the Winterbourne enquiry (Department of Health, 2012) and the introduction of the Transforming Care Agenda, there has been a drive to reduce inpatient beds and to reduce hospital duration for people with ID, and having a clearly delineated treatment pathway can support this process.

Future steps

In relation to the areas covered in this paper, current on-going research and service evaluation within the Brooklands secure service is focussed on evaluating the success of our treatment pathways in relation to re-offending, re-admission or ongoing risk behaviours as well as seeking to explore patient experiences of their treatment pathways.

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Corresponding author

Gareth Hickman can be contacted at: Gareth.Hickman@covwarkpt.nhs.uk

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