**PHL Therapy Team – Pathway**

## Therapy Services Overview

A range of psychological therapeutic interventions as well as activity and therapy pertaining to occupation and meaningful life are available for patients at Priory Hospital Lincolnshire. The therapy pathway offered and provided is aligned on an individual basis to each patient in relation to their psychological, occupation, daily life skill, level of functioning and rehabilitation needs of the patients based on their histories, diagnoses, areas of risk strengths/skills, and current presentation. As a department (and wider service) we are working towards becoming trauma informed in all of our practice that recognises and places value in every opportunity for therapeutic gain, ranging from the simplest of interactions to psychological therapy. We very much focus our practice and care on understanding what has happened to our patients (as opposed to "what is wrong" with them) and providing holistic care that leads to healing, recovery and rehabilitation.

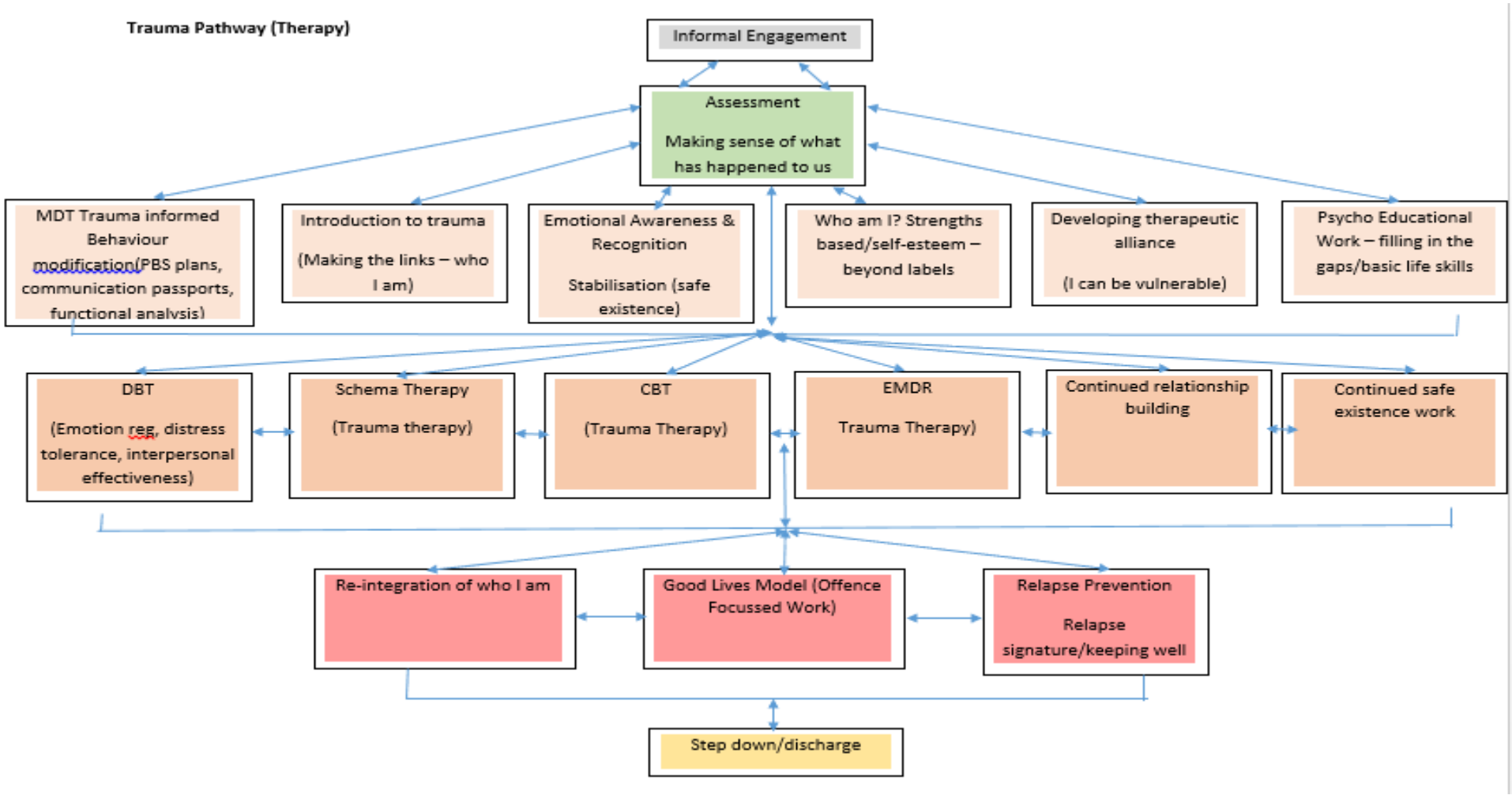
A new four stage recovery and rehabilitation model of care has been in practice within the unit since February 2024 and is broadly presented below:

1. Stage 1 – Assessment & Engagement
2. Stage 2 – Active intervention towards rehabilitation
3. Stage 3 – Consolidation
4. Stage 4 – Discharge planning

The therapy team work within this model of care to deliver care that involves assessment and intervention stemming from a trauma informed approach.

A trauma informed assessment and intervention pathway (utilised and mapped based on individual presentation, functioning and need) has been developed by the Head of therapy (J. Dobson, Consultant Forensic Psychologist), though this remains adaptable and subject to change based on the needs of the patients and service.

**Trauma Pathway (Therapy)**



Running alongside the trauma informed assessment and intervention pathway and in-conjunction with it sits, an array of occupation and meaningful life activity that includes hospital based, working up to community based assessment, activity and intervention. This is delivered on an individual and/or group basis and forms a crucial component of the therapy team's delivery of care sitting within the recovery and rehabilitation model of care.

**Case Study**

Patient X* came to our service after a significant breakdown in the stability of his mental health which resulted in him causing significant damage within his residential property and threatening to harm himself and those around him (his family). Patient X had no known previous psychiatric history, though he had sought help from his GP in the months running up to the incident that lead to admission. Patient X was a hardworking family man who had maintained consistent employment.

Upon admission, Patient X entered the recovery and rehabilitation pathway within stage 1 where our focus was upon engaging with him (and being responsive to his readiness for this) and assessment. Though a typically proud and private man, Patient X engaged with the therapy team with willingness and commitment at every stage of his recovery and overcame personal hurdles around acknowledging the need for and acceptance of help and support. The initial assessment process saw Patient X engage with psychology members of the team in completing a collaborative risk assessment that included a full psychological formulation of his areas of need and risk and supporting management and future scenario plans. The assessment indicated that mental health awareness/insight, stress management and external support (lack of) were pivotal in his mental health breakdown and risk related behaviour and thus an intervention plan (drawn from the above presented trauma informed pathway) was developed and will be detailed later.

Members of the therapy team alongside nursing colleagues also developed a well-being plan (Positive behavioural support) that served to share and communicate with his care team pertinent information around him, his needs and potential trigger areas. Patient X took pride in the development of this and was very much central to its production and subsequent reviews and updates. Early into his stay, Patient X met with the activity co-ordinators who worked hard with him to establish and understand his personal interests, hobbies and activity preferences so as to begin developing an individualised activity planner. Because of his MHA section Patient X was unable to access S17 leave immediately and so meaningful activity was based around what could be accessed within the hospital, however Patient X was keen to engage in the newspaper groups, breakfast clubs and was soon a regular and consistent attender at the mindfulness group to which he maintained his attendance and outside group practice of mindfulness throughout his stay here. An assessment of Patient X's functional abilities was also started in this initial phase of the pathway which largely relied on observational data which very rapidly concluded that Patient X was fully functional in every area and no identified skill deficit. The preparing and cooking of food emerged as an area to develop strength and skill in and so this was taken forward into the intervention/active treatment phase as Patient X moved into phase 2 of his pathway. A shift into phase 2 also coincided with Patient X's MHA section change. Once Patient X's section had changed to a S3, he was assessed for access to the community and escorted access to wider community activity became integral to his recovery and rehabilitation. Patient X was a keen supporter and follower of a local football team and was supported in attending some matches as well as attending a football playing session with other individuals with mental health difficulties. He also attended the off ward fishing trips and found this new hobby to be calming and relaxing for him.

Phase 2 active intervention was fully informed from the outcome of all the assessments undertaken in phase 1. Patient X engaged in mental health awareness work where he was encouraged to reflect meaningfully in relation to his breakdown and the contributing factors whilst gaining insight in to himself. There were educational and relapse prevention components to this intervention. Patient X continued to engage in mindfulness and also completed an intervention

based on emotion recognition and regulation (informed from DBT). Finally Patient X engaged a schema informed intervention where his past experiences were formulated to present an understanding of his coping styles currently. This allowed Patient X to understand his “detached protector” mode and how avoidance had become his default position. Though a range of strategies (largely utilising imagery and cognitive strategies) Patient X was able to decrease this and utilise his healthy adult more.

During phase 2, Patient X also moved toward having unescorted leave and completed his assessments for 2 miles local and 20 miles community leave which he passed with no issues raised. This facilitated his move into phase 3 of the recovery and rehabilitation pathway.

Within phase 3 the focus is on consolidating previous gain and benefit and increasing community access so as to test out any future community plans. This saw Patient X complete relapse signature work and again continue with mindfulness whilst have increasing independent access to the community. This included home leave where he was able to meet with his family until it built up to overnight stays. Patient X’s family were supportive throughout and also open to recognising their subconscious role in his breakdown (emotionally inhibited) and were accepting of external help within the community of systemic family intervention work. Patient X also engaged extensively with the ATS (Assertive outreach service) who provide a b ridging service provision from inpatient to the community and he became ward ambassador and ward rep where he took responsibility in sharing the views and issues of his peers.

The final stage of Patient X’s pathway saw him enter phase 4 which was the discharge planning phase. As Patient X was being discharged back to the family home in was essential that all involved felt ready and suitably supported for this. Patient X worked collaboratively with all involved, accessing joint handover meetings with respective inpatient and community teams and building therapeutic alliance with his new team. Patient X was also supported in beginning some voluntary work and grow his CV so as to move back into employment in the future.