



Insight



Lynn McLeish
Director of
Specialised Services,
The Huntercombe
Group

Welcome to this, our fourth edition of Insight. We are delighted to include articles which reflect our practical experiences within hospitals. We hope to build upon these in future editions. The hospitals within the group are currently extending their portfolio of services to include dual diagnosis in Maidenhead and Roehampton plus step down beds at Stafford. Please contact us for further information on these newly extended services.

“From rubbish to reward”, the introduction of a certificate award scheme on Tamar - an open adolescent unit.

“Our greatest glory is not in never falling, but in rising every time we fall.” - Confucius

Tamar is an open adolescent unit, within The Huntercombe Hospital - Maidenhead for both voluntary and sectioned patients, and admits young people aged 13-19 years old suffering with severe mental illness. These young people often have a background of deprivation, many have experienced abuse during their childhood and educational failure is common. A high proportion of the young people are in the care system, many have past involvement with the youth justice system, and a co-morbid history of substance misuse is common. Tamar unit provides a structured programme from Monday to Friday which consists of education; individual, family and group therapy; skills orientated groups and recreational and sports groups and outings.

Due to the severe nature of their illness or childhood experiences, the young people often find engagement with the unit programme and valuing the unit culture very difficult. The staff challenge was to find a way of changing an in-patient culture from denigration to positive engagement. As the title suggests, we aimed to move away from the perceived view that everything is “rubbish”, to “rewarding” something good.

The vision was to implement a scheme to provide the young people with the first steps in the direction of experiencing something good; feeling valued; and valuing something. The inspiration for the certificate award scheme came from a young girl who had just been admitted to Tamar. This young girl had a history of several failed foster placements, had disclosed abuse and was currently suffering with suicidal ideation and thoughts of self harm.

It was also reported that she was violent and was referred to as being “out of control”. This young girl had a history of being resistant to staff engagement, presenting with oppositional and unpredictable behaviour. When I went to her room and knocked on the door to introduce myself as her Keyworker, I was struck by her room. She had been busy unpacking and I noticed lots of pictures and poems on her wall about death and self harm. Amongst all this darkness I saw a certificate which she had received on a previous unit for her attendance in a group. It was clear to me that she valued her certificate and was proud of her achievement.

The certificate award scheme was developed by the acting clinical ward manager and unit link teacher as a weekly forum to recognise good positive behaviour and actions. Points are allocated on a graded scale for attendance and participation in the unit programme and activities. Each individual would have an individualised and achievable care plan in place, thereby not excluding anyone due to their illness or past experiences. The third certificate is an achievement certificate which is awarded through a nominations process. Any member of staff can nominate an individual for any personal achievement; such as showing a positive contribution to others, or coping well with difficult circumstances. The certificates are presented in a community group by a member of staff and each young person also receives a £2 music voucher, which is a valued commodity for any young person.

The progress of the scheme, although still in its infancy, has provided an element of healthy competition within the unit giving the young people an opportunity to experience success.



Laura Mortimer
Acting Clinical Ward
Manager - Tamar
Unit,
The Huntercombe
Hospital -
Maidenhead

The scheme has proven to be a catalyst for change in behaviours, giving even the most unmotivated and unwell young people the opportunity to stand up in front of staff and their peers and feel proud of what they have achieved. With the histories and experiences that the young people bring to Tamar, denigration is a common way of being. This scheme seems to be encouraging the young people to view themselves and others differently by enabling even the most functionally disabled young person on the unit to have the experience of success.



Psychodynamic psychotherapy in a locked adolescent unit



The provision of psychodynamic psychotherapy for patients in a locked in-patient setting is comparatively rare compared to other psychological therapies and therefore may not be well understood. In this article I aim to try and give some understanding about the rationale and benefit of providing psychodynamic psychotherapy for adolescents in such a setting.

There are two key tasks for psychotherapists in a locked unit. The first task is to provide individual and/or group assessment and psychotherapy treatment for the patients. The second task is to provide a comprehensive psychodynamic formulation for the team's use to help increase the overall understanding of the patients' mental state, ways of thinking, emerging treatment issues, and the ups and downs of their engagement during their stay on the unit.

In assessing a patient, the psychotherapist is attempting to gain a more in-depth understanding of what might be termed the patient's 'internal world'. This includes the nature of the patient's relationships, expressed through the representations held in their minds, the core conflicts and anxieties, and the types of defences or lack of them, which the patient utilises to manage anxiety.

Much of the above will initially be unknown to both therapist and patient and a further understanding will only be gleaned through the exploration of the transference and the counter-transference. By transference we're talking about how the patient relates to the therapist, and to the institution, and this can be complex and take many different paths. The psychotherapist has to constantly evaluate his or her counter-transference which means exploring and understanding the feelings, attitudes and thoughts evoked in the therapist by the patient. Both transference and counter-transference are sources of vital information to further understand the patient's mind and the way they express themselves.



Neil Austin
Child & Adolescent
Psychotherapist,
**The Huntercombe
Hospital -
Maidenhead**

Although the primary function of assessment is to gather information and develop a formulation about the patient, a key benefit in this process is the sense of relief a patient will feel when an attempt is being made to listen, engage with, and genuinely attempt to understand their difficulties. There is a great emphasis on the sense of a joint exploration.

In an acute setting such as the adolescent locked unit the types of patients who are admitted are obviously highly disturbed and come with a variety of diagnoses. Traditionally psychodynamic psychotherapy has not been seen as a first choice treatment approach to young people with such difficulties. However, with modification of clinical technique appropriate to such disturbed adolescents, the psychotherapist can begin to address the pressing need to help the patient develop a capacity to think and manage complex feelings and thoughts. It makes sense that the locked unit provides a safe opportunity to begin that process.



The psychotherapist's first encounter with the patient can be a daunting one. I can think of many fraught first meetings with a frightened, aggressive, or totally silent adolescent, and where it becomes quickly apparent that thoughts are fragmented or don't even seem to exist. It is usual to be met with a variety of reactions including suspicious silence, one-word answers, disjointed fragmented thinking, or a manic outflow, followed by a grudging silence. There are many different examples and variations, but often the result is an initial feeling of confusion or a sense of futility. A key problem with highly disturbed and easily distressed adolescents is managing what can be termed emotional distance. It can often be quite wrong to give a direct type of interpretation, for example interpreting to the patient how he feels he is responsible for damaging his mother.

Most adolescents in a locked setting have profound problems with psychological boundaries, often as a result of disruptive or traumatic experiences in childhood. This means that other people can easily feel overwhelmingly intrusive and threatening because the adolescent cannot properly filter the impact of the other's presence on their thoughts.

I have emphasised throughout this article the importance of developing the capacity to think and tolerate feelings and thoughts, ie. to develop good reflective functioning. I see this task as the main aim of psychodynamic therapy in the locked unit. Currently there is great interest in helping patients develop reflective functioning, particularly in the work of Bateman and Fonagy (2004) who have developed an approach they term 'mentalisation based treatment'. Derived from the Psychoanalysis and Attachment theory, they have developed a psychotherapeutic treatment that aims to help the patient establish a more robust

sense of self so that he or she can develop more secure relationships.

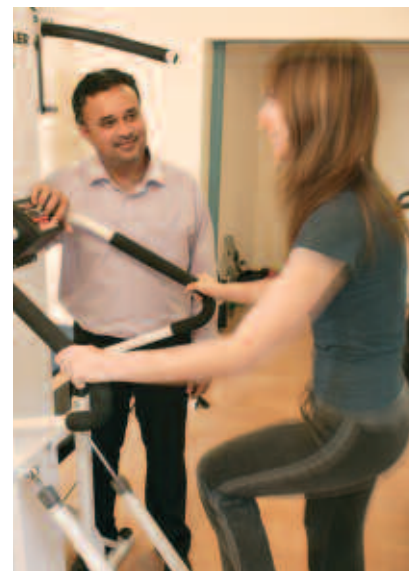
They describe four major treatment goals: identification and appropriate expression of affect; the development of stable internal representations; the formation of a coherent sense of self; and the capacity to form secure relationships.

The above goals are obviously long term and these would not be achieved in the locked setting. However, it is possible to lay down the foundations for a realistic achievement of these goals in our setting. In the first instance there is a need for both emotional and behavioural containment before the patient is able to effectively join in the exploratory task of therapy.

The psychotherapist aims to establish a genuine treatment alliance and this is linked to the work of the nursing team, appropriate use of medication, and targeted affect regulation sessions. This can often take up to six months, sometimes longer, before the patient begins to appreciate the setting and the consistency of the therapy, and where he or she can actually value it.

This is a significant achievement because such patients invariably present with highly negative and dismissive attitudes to treatment. If the patient can value the treatment then this experience builds a foundation for the future and the attaining of the goal of longstanding psychological change and greatly reduced risk.

Finally, the ending of psychotherapy in such a setting is always difficult and complex but it can be successfully managed if both the in-patient and the community teams work well to achieve an agreed plan that allows the patient to safely progress to a new stage in their recovery.



The emotional impact of threats of violence from patients - some thoughts



Dr Andrew Leahy
Consultant
Psychiatrist,
The Huntercombe
Hospital - Stafford

After three years working in an I.C.U / Low Secure setting, I have had to consider more frequently than I considered likely when I first applied for the post of Consultant Psychiatrist, the meaning of threats of violence towards me. In fact I had not considered the possibility that I would be threatened seriously as carefully as I should have. Looking back, I had considered it intellectually but not emotionally. This may sound naive but threats of actual violence are rare in community child and adolescent mental health settings, and even in the long distant days when I worked in adult psychiatry in-patient units including an intensive care unit, I had been threatened only rarely and suffered actual violence on only one occasion. It therefore came as a shock to find that not only did some of the patients, but also their families sometimes threaten me and other staff members.

I have had to consider the meaning of this both to myself and other people. Here I am going to discuss some of the thoughts/emotions I have had which have helped me to come to terms with the issues involved, in the hope that people will be able to use my ideas as a springboard to do their own thinking. It is important to understand that this is a subjective account with no attempt to tackle the topic academically. This does not mean that the writing of others is not important, it is, and I have found it helpful to read the work of others, both academic and subjective.

In essence my experience has been that the early threats to myself came as a huge shock. I had never before been threatened by people saying they intended to kill me. My responses varied

between disbelief and acute anxiety. I hope that I hid the latter to a degree although on one occasion, suspect I did not.

In practice there was a tendency on my part not to take the threats seriously. Certainly at times colleagues had to tell me that I needed to take them more seriously and be more protective towards myself. I found myself on one occasion of being in the curious position of being regularly threatened by a patient but finding that neither he, nor his family, wished to transfer to another consultant's care. After considerable thought I decided to stay with this patient who eventually recovered well enough to return home and, when I met him accidentally in the street in his home town shook my hand warmly and thanked me for treating him. I am still not certain that I did the right thing by continuing to manage him despite the good outcome and do wonder if I should have insisted that he transfer consultants. So what have I learned from the experiences of threatened and actual violence so far?

1. That my tendency to veer between disbelief and paralysis is normal for me.
2. That I can allow this process to happen for me without it actually dominating what I do (as opposed to what I feel).
3. That there are a series of actions that I need to take:

- To discuss with colleagues
- To attempt to discuss with the patient (although generally this has not been possible due to the state of mind of the patient).
- To discuss with the family/carers.
- To discuss with referring professionals.
- To assess the threat in the context of the patient's illness, past behaviour and past experience. This should include formal assessment of risk but also more subjective issues.
- To think about the meaning of the threat to me in the light of my personal and professional experience.

- To think about the threat's meaning to the patient, the family/carers and to other staff.
- To consider involving the police at the point where it is clear the threat is more than just an off the cuff remark.
- To consider issues of my personal safety without trying to pretend that they do not exist and to listen to and take advice that is offered in this area.
- To consider any aspects of my behaviour that may be contributing to such threats and discuss with colleagues.
- To consider the implications for the future of such threats and what, if anything they have to say about threats to the public.

Finally, at a point where I was worried about the potential reality of a threat from a patient, I was given one piece of really useful advice i.e. to take an "unrest cure."* This I did and found it really helpful in putting the patients threat into context in relation to risks I was taking in the rest of my life. So, the benefit for me of the occasional death threat has been a re-evaluation of my priorities and what and where my life is going.

* "The Unrest Cure" is a story by Saki involving changing someone's life from the humdrum to the exciting.



LEADING THE WAY IN SPECIALISED SERVICES

The Huntercombe Hospital - Maidenhead

Huntercombe Lane South, Taplow,
Maidenhead, Berkshire SL6 0PQ
tel: 01628 667881 fax: 01628 662087
email: huntercombe.maidenhead@fshc.co.uk

Huntercombe House - Stockton

3 Norton Court, 201 Norton Road,
Stockton-on-Tees, Cleveland TS20 2BL
tel: 01642 361343 fax: 01642 363 860
email: huntercombe.house.stockton@fshc.co.uk

The Huntercombe Hospital - Edinburgh

Binny Estate, Ecclesmachan Road, Uphall,
West Lothian, EH52 6NL
tel: 01506 856023 fax: 01506 865270
email: huntercombe.edinburgh@fshc.co.uk

Dene Hall

Station Road, Easington Colliery,
County Durham SR8 3SP
tel: 0191 527 0554 fax: 0191 527 9836
email: dene.hall@fshc.co.uk

The Huntercombe Hospital - Stafford

Ivetsey Bank, Wheaton Aston,
Stafford ST19 9QT
tel: 01785 840 000 fax: 01785 842192
email: huntercombe.stafford@fshc.co.uk

Huntercombe Centre - Sunderland

Leechmere Road,
Sunderland, SR2 9DJ
tel: 0191 523 5516 fax: 0191 523 5313
email: huntercombe.centre.sunderland@fshc.co.uk

The Huntercombe Hospital - Roehampton

Holybourne Avenue,
London, SW15 4JL
tel: 020 8780 6155 fax: 020 8780 6156
email: huntercombe.roehampton@fshc.co.uk

Granville Lodge

24 Granville Avenue, Hartlepool TS26 8ND
tel: 01429 222247 fax: 01429 236388
email: granville.lodge@fshc.co.uk

Nottingham Neurodisability Service - Hucknall

Hankin Street, Hucknall,
Nottinghamshire NG15 7RR
tel: 0115 968 0202 fax: 0115 964 2747
email: nottingham@fshc.co.uk

Blackheath Brain Injury Rehabilitation Centre and Neurodisability Service

80-82 Blackheath Hill, London SE10 8AB
tel: 0208 692 4007 fax: 0208 694 8316
email: blackheath@fshc.co.uk

Frenchay Brain Injury Rehabilitation Centre

Frenchay Park Road,
Bristol BS16 1UU
tel: 0117 956 2697 fax: 0117 956 9941
email: frenchay@fshc.co.uk

Nottingham Neurodisability Service - Aspley

Robins Woods Road, Aspley,
Nottinghamshire NG8 3LD
tel: 0115 942 5153 fax: 0115 942 5154
email: aspley@fshc.co.uk

Central Scotland Brain Injury Rehabilitation Centre

Murdoch Castle, Newmans,
Wishaw ML2 9BY
tel: 01698 384 055 fax: 01698 386 099
email: central.scotland@fshc.co.uk

The
Huntercombe
Group

www.huntercombe.com

