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**DEADLINE FOR
NEXT NEWSLETTER:
31 JANUARY 2008**

FROM THE EDITOR



I would like to wish strength for the winter ahead and welcome you to another edition of the ISPS UK Newsletter. The expanding of the possibilities of what can be included and talked about openly in the newsletter reflects the expansion of activities that our organisation has been involved. This is recognised in the piece from the committee meeting.

The current issue's contributions range from creative work to good practice recommendations. The book review of the most recent and very well received ISPS UK book 'Experiences of Mental Health Inpatient Care', spells out difficulties and harsh realities of working in mental health inpatient settings. Moreover, we are aiming to develop a regular poetry corner



Vasiliki Gkotsi: www.numasters.com/artists

initiated in this issue by Janey Antoniou.

Creative expression and communication is central to ISPSUK. We would like to further develop creative content of the Newsletter, with contributions from users, carers and professionals. It can be helpful in terms of continuity and communicative interactions within our community.

Enjoy.

Vasilli Magalios



LETTER FROM THE CHAIR

By the time you read this, holidays will probably be a faint (hopefully pleasant) memory and you will be back into panic mode of trying to keep too many plates in the air at the same time. So I won't delay you with a long letter but just a few key bullet points.

The revised Code of Practice will be a key adjunct to the new Mental Health Act, containing details we will want to influence if we can e.g. on the components of Supervised Community Treatment Orders. I understand there will be a 12-week consultation period starting in October, time enough for us to coordinate an ISPSUK response if we get organised.

Our next conference is in Newcastle on Feb 1st 2008 on the theme of 'Working with Families who live with Psychosis'. Alex Reed, Brian Martindale and Jen Kilyon have got together a programme that goes to the heart of the issues, so come if you can and please make sure anyone you know who is interested knows about it.

This promises to be another stimulating event.

Our committee is working on a new Strategic Plan for ISPS UK - see Committee News. The outcome of the last one in 2005 has been quite good - a number of objectives were achieved, like meeting half our running costs out of members' subscriptions, holding conferences around the country - in London, Newcastle and Bath - and becoming a NICE stakeholder. I hope talk of strategic plans won't bore you and we can engage you in the new one - it's about ensuring that we have the most relevant aims for our members.

We are setting up a Bursary Fund to help service users and carers to attend our conferences (as an alternative to raising conference fees across the board). Information about this will reach you with your renewal letter and donations will be very welcome. If you currently pay by cheque/card please do consider switching to a Standing Order. It saves us time and money, which helps us as a charity. (And if you currently have an SO for £10 and can afford the

new fee of £30 we would appreciate it if you can make the change.)

An ongoing aim is to develop local network meetings where members live. We have a number of new contact people whose email addresses are in this newsletter. It's great that we have the beginning of a network in Scotland (contact: Alf Gilham) and that meeting may be restarting in London in the near future (contact: Sheila Grandison). Do email your local contact if you want to meet up with other ISPS people in your area.

And good luck with the autumn surge.

David Kennard, Chair

REHABILITATION AND RECOVERY: *first steps*

João Botas, Clinical Psychologist (SoE)

For the last six years I have been managing a seven bed registered care home that provides short-term rehabilitation, i.e. development of practical living skills and person centred therapeutic interventions to people with severe mental illness.

Throughout this time, clients, staff and I have been developing a recovery approach to our service provision. In our service we believe and promote that people can recover from mental illness, i.e. service users can live a more meaningful, satisfying, hopeful and contributing life even, as they grow beyond the effects of mental illness (Anthony, 1993). It is with this in mind that I would like to share with you some aspects of the work we do around personal recovery.

The first steps start with our comprehensive assessment before admission. First, there is an introduction visit to the service where the client and his/her carer(s) get to know the staff and house. Ethos of the home, house rules and practical aspects of communal living are also discussed. At the end of this meeting a Personal Recovery Plan is given to the prospective resident to

fill in before the second meeting takes place. A Service User Guide is also given to the client and carers providing further information about the house and staff team.

The second meeting focuses entirely on the Personal Recovery Plan. This tool was developed by Ron Coleman (1999) with the aim to assist the service user in terms of his/her recovery. This plan is constituted by the following sections:

1) What does recovery mean to you?

2) About yourself - An auto-biographical section, i.e. childhood, school, adolescence and adult life memories, relationships, strengths/weaknesses, important achievements, money situation, physical health, spiritual & cultural life and sexuality;

3) Difficulties - 'Things I find difficult in my life?' and 'How have difficulties affected my quality of life?'

4) Coping skills - 'What do you do to cope with your difficulties?' and 'What does not help you to cope?'

5) The mental health system and treatments -

brief description of treatments including medication, talking therapies and relationships with mental health staff;

6) Plan for change - the service user identifies the things he/she would like to do in the future;

7) Personal development plan - things about the service user's life that he/she would like to change, steps necessary to take to make the change happen, and barriers to achieve this change.



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Whilst the former five sections help staff to get to know better the client and contextualise his/her experiences, the latter two form the basis for the future care plans that will be developed in partnership during his/her stay at the home. These care plans, usually written and signed by the client, promote, amongst other things, self-esteem and self-determination. For example, they can vary from 'Getting up everyday by myself at 08:00am' to 'To find a job'. These plans should reflect realistically the degree of autonomy and independence displayed by the service user, i.e. should respect his/her pace and be achievable. It is with this in mind that they are regularly reviewed throughout his/her stay.

This second meeting is also important in terms of appreciating how committed, motivated and aware is the service user in his/her own journey of recovery. Sometimes this is the first time that the client hears about the idea of recovery and its new language. In this case the intervention needs to be one of introducing this idea to the client. Other times the Personal Recovery Plan is filled in by the Social Worker or CPN with little or no involvement from the client. And then there are also times when the client refuses to fill in the plan

and be referred to the service. Normally, these referrals are not accepted.

However, most of the times, the client is committed and willing to work on his/her plan of recovery. This is usually two fold: 1) developing his/her practical living skills, such as, cooking, shopping, personal care, 2) developing self-management skills, such as, learning how to cope with the voices, self-medication, developing social support with family and friends, advanced directives. The peer support from fellow residents, encouragement and optimism from staff and the involvement of carers facilitate and stimulate personal recovery.

After the second meeting the client is invited for dinner with the group of residents. This allows the current group to meet the prospective resident in an informal manner. But it also is an opportunity for the client to experience what it is like to be in a communal setting. A decision is made after consultation with staff and residents. If the client is offered a place and accepts it, he/she can opt for a slow admission period.

Since the experience of recovery from mental illness is such a uniquely personal and diverse experience we need to approach it with caution.

That is why the Personal Recovery Plan is such a useful tool because it starts from valuing and respectfully understanding the person's experiences from his/her own perspective.

The central issue is recognising the importance of the subjective experience of the person rather than applying external professional or societal expectations of recovery to any individual except when behaviour becomes damaging to the individual or society.

'For me recovery does mean learning to cope with my difficulties, gaining independence, taking responsibility for myself, being honest with myself, achieving my goals, developing my skills and fulfilling my dreams – including my dreams to be well'

D.C. (Comment from an ex-resident)

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‘Going Carefully’: Safe Ways to Apply Integrative Psychotherapy

Sharron Smith

Those of you who attended the ISPS conference “Working with Emotion in Psychosis” last November might remember Dr Sue Hingley’s interesting presentation exploring emotion and meaning within the experience of psychosis. She provided an overview of psychodynamic theory and made links to humanistic and cognitive-behavioural perspectives. As a qualified clinical psychologist and integrative psychotherapist in training, I was fascinated by her talk and intrigued by a question subsequently posed by an audience member. Dr Hingley was asked about how she managed the risks of psychotherapy in working with clients who experience psychosis and her response, as I remember it, was “Go carefully”.

Within the psychotherapy literature, particularly relating to psychoanalytic and psychodynamic psychotherapy, concerns have been expressed about therapy potentially being harmful for clients who experience or are vulnerable to psychosis (Lehman, Steinwachs and the Co-Investigators of the PORT project, 1998; Lemma, 1996; Rosenfeld, 1987). However, there are counter-claims suggesting psychotherapy is

potentially harmful for all clients (Gottdiener & Haslam, 2003) and therapeutic activity can be adjusted for clients who experience or are vulnerable to psychosis (Ver Eecke, 2003; Prouty, 2003). In seeking to apply Integrative Psychotherapy principles to my practice with clients who experience psychosis, I am left wondering about the practical significance of these ideas. As part of my training, I plan to complete a qualitative research project that aims to elucidate the notion of ‘going carefully’.

In order to do this, I am looking for Integrative or Relational Psychotherapists who have at least five years experience of conducting therapy with clients who experience psychosis. I am seeking to gather the wisdom of their experience through a semi-structured interview, exploring the context of their work and their understandings of safe ways of working with clients who are vulnerable to psychosis. If you are willing to consider taking part in the study please contact me, (drsharron@hotmail.com), so I can provide more information about the project. If you decide to participate, we will meet at a time and place that is

convenient for you, for about an hour to an hour-and-a-half, to conduct an open, conversational interview. Eventually, I hope to invite comment on the study’s initial findings through the ISPS email discussion group.

Sharron Smith is a Clinical Psychologist and an Integrative Psychotherapist in training

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PSYCHOSIS

*Dabble the brush in black phenol-laced paint
and draw it across both the eyes.
Hope that the burning will block out the sights
that are still only seen in the screams.
Shut out the movement of large men and small,
of lunar men all dressed in white.
There is a young harlequin - less than three feet
who laughs and who tumbles and falls.
Silence the voices, mute out the howls
of the ones who take over the world.
The white persian cat with the rose in it's teeth
hisses at us and retires.
Then the music-man comes in his blue pin-stripe suit,
his blue bowler hat and no eyes.
We sing all at once with our feet on the ground
reassembled left, right, (next) left, right.
The music is tonal, harmonic and true,
the walls and the people are too,
normality trembles a sigh of relief,
the others are biding their time...*



by Janey Antoniou

50 Years of Humanistic Treatment of Psychoses: the history of ISPS 1956-2006

430 pages, 25 chapters



Contributors include:

Yrjo Alanan, Johan Cullberg, Brian Martindale, Jan Olav Johannessen, Gerd Ragna Bloch Thorsen, Pat McGorry, Manuel Gonzalez de Chavez, Chris Burford, John Read, Brian Koehler and many more.

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Me and You, Tate Modern and Portugal Prints: New Ways of Working Together in Mental Health

Natasha Soares, Liz Ellis, Ad Christodoulou

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The Guardian ran an article on June 13th in its Society pages about the need for mental health policy makers to consult the service users whom their policies directly affect, in a way that removes the imbalance in power that is inevitably present between the two parties.

The suggestion in the article, by Clare Allan, was to move away from "inane surveys" which impose their own agenda, to policy makers looking at views already expressed in internet-based group forums, blogs and the like. On offer at Tate Modern on June 13th was the beginning of a trial of a very different way forward.

The community department at Tate have worked together with Portugal Prints, Westminster Mind's mental health rehabilitation project, to put together a series of workshops which invite the two groups, mental health service users and mental health policy makers, to work alongside each other at Tate Modern with the shared task of discussing and creating artwork.

The work under discussion was carefully selected for its relevance to the group; role, image and identity were predominant themes.

Liz Ellis, the curator of community events at Tate Modern led the workshop together with Steve Grimes, an artist and mental health service user. The time was split between the chosen artworks in the galleries and hands-on creative activities in Tate's studio, with a short time for feedback at the end of the two hours. As soon as the group was seated around the first painting, *Woman with a Bag*, by Karl Schmidt-Rotluff, discussion began: "She's got a lot on her mind", "The weight of the world is on her shoulders", "She's in a dilemma". It was clear that both the service users with their first-hand experience of depression and anxiety, and the policy makers with their heavy responsibilities and hectic work schedules, identified with the subject matter and had plenty to contribute. As we moved

on to Dubuffet's "The Busy Life", the words "rushing", "scattered", "chaotic", "dominant", "violent", came pouring out and everyone had something to say. As we could see, this was an artist expressing untidy emotions.

The next work we looked at was Eileen Agar's "The Autobiography of an Embryo", where the group split up to discuss small sections of the painting. Finally, we took part in an exercise in front of the etchings of Wols. We worked with partners, observing the lines on each other's hands and drawing them. We followed on by learning about a small part of the life of Wols and how at the time he produced these etchings; he had been sleeping rough in a car in France, after escaping enlistment in Germany in the 1930s. Somehow Wols had continued to produce art, somehow his friends had managed to get hold of these etchings and they had been preserved in all their strange fragility. There was something incredibly

touching about the resonance of this work, made in difficult and vulnerable personal circumstances yet surviving and eventually becoming valued in the context of an international art gallery.

The group soon began to interact in between the actual artwork-based discussions; the short walks through the galleries between works became a highly valuable discussion period. At one point, Claire Murdoch, a Chief Executive of Central and North West London Mental Health NHS Trust, commented that she had been very moved by the amazement of a service user in experiencing the galleries. As we travelled down escalators we gladly recognised that there is no wrong answer to what can be seen in an artwork, and that everyone's ideas are equally valid and valuable in the gallery context.

The second part of the workshop was led by Steve Grimes, who encouraged everyone to have a lot of fun! He helped us to use the verbal and pictorial notes we had made in the gallery as a starting point for adding texture and collage. This aspect of the workshop seemed particularly enjoyable to those people who spend most of their working day in offices and meetings; the

hands-on creative experience was proclaimed by at least one policy maker to be simply wonderful.

The feedback from the workshop was collected both by comment in the group and by questionnaire, and was unanimously positive. Everyone who attended said they would like to attend a future workshop of this kind. Some service users indicated that they would definitely revisit Tate Modern in their own time, (this was a first-time visit for 75% of service users in the group). Claire Murdoch, the most senior policy-maker attending, felt that the workshop was "brilliant" and highly appreciated the opportunity of meeting service users in an environment as creative, stimulating and important as that which is offered by Tate Modern.

The aim of these workshops is to allow mental health policy makers and those whose lives are directly affected by their decisions to meet each other. What happens next is up to both groups involved. However, it is, as



Clare Allan wrote, important to ensure that the disempowerment experienced by service users does not lead to an imbalance in that encounter and a skewing of outcomes. As we drew the lines on the palms of each other's hands in front of the Wols etchings, what we touched on was the shared humanity of all the participants - surely the most effective and far-reaching result of any meeting between these groups.

The Me and You project continues with another workshop at Tate Modern on July 4th,

Three follow-on workshops at Portugal Prints throughout August, a presentation to the Northampton University conference, Inspiring Transformations in Arts and Health, and an exhibition of all artworks produced at Westminster City Hall in October.

Committee Stop Press: Strategic Goals for 2008/9

David Kennard

On Wednesday October 3rd the still quite new ISPSUK committee met for the whole day to plan its strategy for the next 12-18 months. This is a brief report to catch the Newsletter - more details will emerge later.

We last did this as a committee a couple of years ago. This time the day was a lot better prepared, starting with a review of the outcomes of the last plan. Highlights included

➔ We now cover half our running costs from members' subscriptions which provides a more secure base than when it all depended on conference numbers

➔ We have achieved our goal of at least two conferences a year, one in London and one in the North East

➔ We are beginning to develop our profile at national level, becoming a stakeholder in the review of the NICE Guideline on Schizophrenia

➔ We have developed our info on benefits of membership, which is now much clearer, and includes the 20% discount on ISPS books – around 20 members have taken advantage so far.

We did the tried and tested SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) – our strengths include being open minded, diverse, enthusiastic; weaknesses include dependence on key individuals like the chair, lack of money and no representation of BEM community; threats include the speed of change in the NHS but opportunities also included being well placed to contribute to the revolution that is occurring both in service delivery and in the scientific understanding of schizophrenia.

And we came up with a clutch of a dozen goals for the coming year or

more, not necessarily in this order of importance:

1. To produce a charter of good practice in psychological therapies for the psychoses
2. To develop a clear support plan to help members develop local networks of members in their own region.
3. Continue to be financially viable.
4. Continue to expand our membership and to be clear about the advantages that membership brings.
5. Develop a marketing strategy clarifying our image and what is unique about us.
6. Be responsive to current key agendas in our field (e.g. MHA Code of Practice).

ISPS UK COMMITTEE AND ASSOCIATE COMMITTEE MEMBERS

Elected members:

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7. Maintain our lively email discussion groups.

8. Development of the website

9. Development of the newsletter and communication with members' wider networks

10. Continue to run conferences, with relevant follow up activities.

11. Taking forward the proposed name change

12. Planning for the well-being and sustainability of the committee

We worked on an action plan, so that each goal is the responsibility of particular members of the committee, with specific targets and delivery dates where appropriate. This is the first time we have tried to be this business-like in planning what we do - and we also enjoyed the day, as the photo of those present (opposite) shows.



*SOME OF THE ISPS UK COMMITTEE at the
PLANNING DAY*

*Back row L-R: Chris Burford Alex Reed
David Kennard Steve Trenchard Brian Martindale*

*Front row: Judith Varley Sheila Grandison Gráinne
Fadden Jen Kilyon*

*(Not pictured) Janey Antoniou, Trish Barry, John Gale,
Alf Gilham, Vasili Magalios and Dan Pearson.*

Managing Madness

Fiona McGruer

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This article is part of a paper delivered at the 2007 Annual Conference of the Association of Therapeutic Communities in Windsor

Approximately 18 months ago, Dr Jan Birtle and I established a small internal consultancy arm, working title Dynamo, with specialist expertise in clinical teamwork, specifically in improving the capacity for team emotional intelligence or psychological mindedness. The basis of this approach is psychodynamic-systemic and utilises skills and knowledge originating in clinical practice applied and adapted to organisational interventions.

The term 'Dynamo' here represents 'DYNAMIC Management in Organisations'. The concept of a dynamo also refers to a device which re-directs energy; it is a vehicle capable of transforming otherwise redundant energy into a creative force. A dynamo makes best use of the limitations imposed by natural laws, namely that energy can neither be created nor destroyed, and it can only be converted from one form to another.

The work of Dynamo responds to our knowledge of the difficulties prevalent in all mental health services leading to a reduced capacity

to provide effective services. In response to this we focus on increasing the performance of individuals, teams and the wider organisation by mobilising efforts to improve the quality and effectiveness of client work. Clinical issues are at the centre of this enterprise.

I am very interested in the impact of clinical work on individuals and teams. I can see clinical disturbance such as psychosis, suicidality and self-destructiveness etc. not only getting into staff and teams, but severely affecting their functioning. The fragmentation of disturbed states of mind can split teams as they carry the intolerable parts of patients.

Particular difficulties of providing mental health services arise from the nature of the clinical work, where dealing with psychosis, or madness, is a central feature and daily task for all front line staff. This is a significant pressure and the psychosis, or elements of it, of necessity get into staff that are working in an effective, emotionally engaged relationship with service users. In turn psychosis, or aspects of madness, also find their way into clinical teams and, if left uncontained, ultimately may

pervade the entire organisation.

The impact of this can be felt in a number of ways, notably through staff becoming emotionally drained, exhausted, physically or mentally ill and eventually leading in some cases to complete burn out. Defence mechanisms, a concept utilised in the practice of psychodynamic therapy, are a normal human reaction to pressure and are accepted as having a protective function. They are usually accepted as being manifest through unconscious processes. In other words there may be little or no self-awareness that defences are operating. When unmanageable pressures or stresses are experienced defences can be utilised to excessive proportions, either in short bursts in response to acute stressors, where they may lead to emotional outbursts, or over a longer period of time resulting in emotional distancing. This in turn leads to a lessening of effective reality testing, reduced emotional engagement with service users, with consequent lack of effective clinical impact, and withdrawal from colleagues

which diminishes the capacity of the multidisciplinary team.

One presentation of this can be seen when staff become insular, sometimes being described as akin to existing in a psychic retreat or autistic bubble. Similar mechanisms occur in teams and in the wider organisation. Must acknowledge the work of Isobel Menzies-Lyth in describing the splits between managers and front line nursing staff in acute services in the 1950s. Despite this thorough research and that of many others since, continuing difficulties persist in modern services. Cyclical patterns of dysfunction can occur and are difficult to arrest and reverse into more productive service provision.

It is important to remember that working with disturbed people, particularly if staff are emotionally engaged is a disturbing experience. The disturbance that is transmitted from service users to staff can result in staff feeling burdened, compensating by them becoming split and insensitive. They can become risk adverse rather than engaging with service users to help them think about their own risks. There can be an atmosphere of anxiety, fear, intimidation developing (what if I do the wrong thing) and divisiveness in teams leading to people feeling that they are working in isolation. The emotional burden on individuals can be extremely high.

Teams that work well take time to form and there are crucial elements including leadership, fellowship engagement in the task that contributes to this. Specifically, we have noted a need to improve the psychological mindedness, or to use a more prevalent an emotional intelligence of clinical teams. In a team that is working well, there will be the capacity for open debate, reflective thinking, responsive and supportive listening, capacity to resolve conflict, confidence in role and a proactive approach to the clinical work. The team will be able to pull together a full picture including emotional reactions of team members, which will support decisions about risk management, and this in itself requires significant teamwork. An effective team will also be able to be open about this risk management process and to a greater or lesser extent depending on the clinical issues with the service users in a collaborative venture to improve their experience.

The work we are involved in is informed by our learning with teams we have engaged with. It echoes the findings of Menzies-Lyth and supports the need for active thought to be given to the need for emotional

containment, with particular specific emphasis in organisations specialising in the field of mental health provision.

In other words, the capability of an organisation to provide effective mental health care can be increased by improving the psychological mindedness of the organisation. To be fully effective this needs to run through all levels of a specialist mental health provider organisation.

This approach, in our experience, is most effective when supported by robust management in the organisation. This includes clear line management arrangements, appraisal processes, clinical supervision and working conditions. Training and the encouragement of learning in the organisation are essential aspects and in times of limited skilled resources consideration needs to be given to the best use of specialised expertise.

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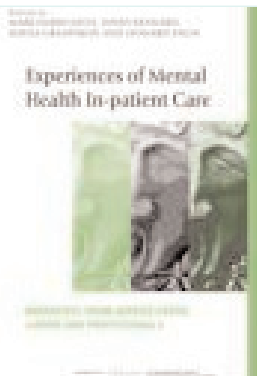
BOOK REVIEW

Mark Hardcastle, David Kennard, Sheila Grandison, and Leonard Fagin (editors): *Experiences of Mental Health In-patient Care: Narratives from Service Users, Carers and Professionals*. ISPS UK: Routledge, Paperback, 218 pages, £19.99.

Reviewed by Steve Klein, a Regional Director for the Mental Health Act Commission (MHAC)

I would like to thank Janey Antoniou for asking me to review this book. Without the requirement to produce a few hundred words, I probably would have stopped half-way through; not because it is a difficult read. Indeed its structure makes it a fluent commentary on mental health in-patient care, but because of the direct effect it has had on me. As I turned the pages, I found myself thinking two contradictory thoughts: 'but that's awful' and 'so, what else is new?' It leaves a bad taste in the mouth firstly of because it is a unique book, and secondly that it in the twenty-first century it still needs to be written.

I first set foot in a psychiatric hospital 35 years ago. Like many of the authors I found it a bewildering experience. However, the one thing I knew was that I was sane. We all drank our coffee from NHS cups, stamped on the bottom with the year of manufacture. I made a mistake on my second or third day and was put right immediately: Sane people used yellow cups and mad people used pink cups.



This symbolic affirmation of the differentness, otherness of patients echoes throughout the accounts of both staff and service users in this book.

The pain, loneliness, loss, fear, and confusion described by service users seem unbearable for them and those around them. When people are admitted to hospital they bring their pain with them, and those providing care are faced with the challenge of its proximity on a daily basis. Many years ago, at a high secure hospital I watched while a patient prepared to leave the next day. A weary nurse turned to me and said 'Bastard. He's only done six years; I've got another eight to do.' The pain of patients in high secure hospitals runs very deep. For a staff member truly to accept the distress of other human beings day in, day out, is more than

most of us could bear. So, all those involved create structures, rules, and defences for their protection. This book provides an excellent description of these protective devices and the effect they have on all those who meet on an in-patient unit.

The authors describe formal rules which avoid the necessity of thinking about the real needs of another human being: 'if we give one patient a drink at night everyone else would want one.' No patients can have sex. A hospital recently informed me that it did not provide an education programme because such a programme would discriminate against those whose mental state does not allow for long periods of concentration or focus. In a hospital setting, the power differential between the caring and the cared for is more overt than any other part of health care. Claire Ockwell and members of the Capital project describe the terror and humiliation of restraint and seclusion. A number of the authors talk about the symbolic importance of locked doors and keys.

Two-thirds of all wards are now locked; and those doors are locked on informal and detained patients alike. So, everyone has to ask to be let out. Even in the hands of the kindest person, this act of asking is a reinforcement of difference. So, too, is the control of information. 'No one explained what was happening to me...I wanted someone to talk to me,' says one service user. Another discovers the hard way that Largactyl makes the skin sensitive to sunlight, because nobody remembered to tell him.

On every visit, we in the Mental Health Act Commission consider whether detained patients, those with the least power of all, understand the rights and the legal framework that has been used to protect them and others. I frequently hear staff say: "I gave him his rights" which sounds all too much like a policeman intoning a ritual set of words when arresting someone. It is too easy for those familiar with the world of the ward to assume that everyone understands it. The memories of staff describing their first impressions match those of carers and patients bewildered by the noise the rules, the apparently irrational behaviour of all present.

At the heart of this book is the need for everyone to be heard, accepted, and validated. Members of staff who lock themselves in the office are failing in their

duty simply to be alongside another human being. Managers who cannot be along side such staff are complicit in the process. The voice of carers, seen as over-involved or interfering is the voice of people in pain, unfiltered by either the official role of 'patient' or the rules of the organisation.

Despite the plethora of criticisms, the book is filled with the humanity of caring individuals. The CEO may have to worry about delivery against NHS national targets, but still tries to remember 'the Jimmy Test'. The Hotel Services Assistant / Domestic values the normal human contact she has with the patients on her ward. Ward staff recognise the value of walking with a patient in the grounds. An art therapist argues for the use of art as a way of communicating pain. All express the importance of simply listening to what the service user has to say.

The book does not argue that staff should cease to contain and protect patients. Compulsion may be necessary. But we are forced to think about when this is the case, how to achieve it. For those involved in compulsion; the task should be carried out without engendering shame creating a sense of punishment. The struggle to make a correct decision about compulsion is beautifully described by a nurse, Geoff Brennan.

Very early on in my

career a nurse showing me around a ward, ushered me into the seclusion room, shut the door and walked away. I was only secluded for a few minutes, but the memory of that cold, dark, lonely room where I was imprisoned, not knowing for how long, remains to this day. 'Put yourself in his shoes' is the message of this book. The introductory words of Rachel Perkins, a director of quality assurance and user carer experience set the tone: everyone involved: doctor, nurse, patient, carer, domestic, psychologist; everyone is an expert and we should listen to the experts. Each chapter describes one aspect of the ward from several perspectives: the psychiatrist reviews the patient's contribution; the nurse that of the chaplain. We all live in the same world, but all see it differently.

"Experiences of Mental Health In-Patient Care" is structured to remind us of that. It includes group exercises to disconcert us; to force us to hear new ideas. Everyone involved in in-patient care should use it. The message is: be unsettled; be very unsettled.

LOCAL NETWORKS, ANNOUNCEMENTS and CONTACTS

EAST ANGLIA

Calling East Anglian members, specifically Norfolk and Suffolk. If you are interested in the formation of a local member's network with the possibility of arranging a local meeting, please contact

mary_rose_roe@hotmail.com

LONDON

Contact Sheila Grandison,
sheila@barendt74.fsnet.co.uk

NORTHERN

The September meeting had to be postponed, a new date will be announced on the email list. Contacts Gary Brownbridge and Jen Kilyon,
gbrownbridge@retreat-hospital.org
and kilyon@blueyonder.co.uk

SOUTH WEST

Contact: Gina Smith,
hssgfs@bath.ac.uk.

WEST MIDLANDS

Contact Gráinne Fadden,
grainne.fadden@bsmht.nhs.uk

NORTH EAST PSYCHO- DYNAMIC AND PSYCHOSIS INTEREST GROUP

The Psychodynamics and Psychosis (North East) Special Interest Group is now in its third year and is going from strength to strength. We have organised two meetings this year with an attendance of over 20 people on each occasion. We are building-up generous and creative resource with members from all the main disciplines, and from within and without the NHS. Although the meetings are focussed on advancing our understanding of psychodynamic approaches to psychosis, attendance by professionals whose main expertise is in CBT, systemic, integrative, or biological approaches has enriched the group and our discussions.

On Friday 21 September 2007, Mandy McCoull, Head Art Therapist at St

Georges Park, Morpeth, gave a case presentation of her art therapy over 3 years with a woman struggling with a psychotic breakdown. Using slides of this woman's art-work, Mandy guided us on a powerful journey, demonstrating how her patient started to gain confidence in her art therapy and to use it as a container for her fragmented state of mind. It was clear that through the art-work acting as a container, and through Mandy's sensitive relationship, her patient was able to start to tolerate the parts of herself that she had found so frightening, and work towards a more secure recovery.

In addition to the above two meetings, two regular contributors to our Psychodynamics and Psychosis Meetings, Ian Thurston and Dr Jose Quinn, are presenting at a conference in Newcastle on Friday 30 November 2007, entitled "Working at the Coal Face: Mining the Disturbance at the Heart of Complex Psychiatric Morbidity."

Psychodynamics and Psychosis (North East) is an

ISPS(UK) Network Group and we welcome attendance from anyone interested in Psychodynamic Approaches to Psychosis. If you would like any further information, or would like to be informed of our 2008 meetings by email, please contact Richard Duggins, SpR in Psychotherapy, Claremont House, Regional Department of Psychotherapy, Newcastle upon Tyne:
richard.duggins@ntw.nhs.uk

SCOTLAND

Contact Alf Gillham,
alf.gillham@ggc.scot.nhs.uk

SPECIAL INTERESTS:

FAMILIES

Dan Pearson
daniel.j.pearson@talk21.com

SOCIAL WORK

Trish Barry
trishbarry515@hotmail.com

NURSES

Keith Coupland
keith@furlong.demon.co.uk
or Mark Hardcastle
mark.hardcastle@wshsc.nhs.uk

ARTS

THERAPIES

Sheila Grandison
sheila.grandison@elcmht.nhs.uk

GENERAL PSYCHIATRY

Chris Burford,
cburford@gn.apc.org

FORTHCOMING EVENTS

Date: 29-30 November 2007

Event: The early phase of psychosis - research and treatment: An International Conference

Organisers: Institute of Psychiatry / International Early Psychosis Association - 01355 244966

Location: London: Institute of Psychiatry

Date: 4th December 2007

Event: Mental Health Today
Organisers: Mental Health Today, London - 0870 8901080
Location: Business Design Centre, Islington, London

Date: 13-14th December 2007

Event: Psychosis: Early Intervention and Innovation
Organisers: University of Leeds - Leeds Family Therapy and Research Centre - Debbie Duce, 0113 3433452
d.f.duce@leeds.ac.uk
Location: Leeds

Date: 1 February 2008

Event: Working with Families who live with Psychosis
Organiser: ISPS (UK) North East: 2nd Annual North East Conference - Gill Brown 01661 886063,
gill@dissingtonhall.co.uk
Location: Royal Station Hotel, Newcastle

DEADLINE FOR NEXT NEWSLETTER:

31 JANUARY 2008

NETWORKING

ISPS UK EMAIL GROUP

Don't forget that you do not need to wait until the next Newsletter if you have something to say or want to hear what others have on their minds! The ISPS UK email discussion group is alive and lively - and for all members with email access. If you are not signed on contact Chris Burford:
cburford@gn.apc.org or Denise Rolland,
admin@isps.org.uk.

ISPS UK CONTACT DETAILS:

Denise Rolland, UK Administrator can be reached at
admin@isps.org.uk.
Should you feel that an event that you are involved in would be of interest to our members please contact Denise for further details on advertising in our Newsletter.

The ISPS UK website is at www.isps.org/uk

One of the strengths of ISPS UK is the bringing together of a wide range of views, however the views expressed by authors in this newsletter are not necessarily shared by ISPS UK as a whole.