

Cygnets Hospital Bierley



New Dawn Ward

Service Overview

New Dawn is our low secure ward for the care and treatment of women with a diagnosis of Borderline Personality Disorder. We undertake the treatment of complex cases with multiple difficulties such as eating disorders, substance misuse, short-lived psychosis as part of Borderline Personality disorder and ADHD and have recently been awarded the Laing & Buisson Award for Nursing Practice at the Independent Healthcare Awards 2008.

The low secure takes on clients where there is a relatively high risk of harm to self or others. We also consider clients for the secure setting where the risk is lower but where difficulty in engagement in treatment is marked and previous attempts have failed. We only accept clients where there is primarily a personality disorder that we feel is treatable.

Additionally, we are now able to offer a step-down facility to an open ward, suitable for clients who have made significant progress through the New Dawn Program. This provides an ideal stepping stone between the confines of a secure environment and an eventual return to independent living. Clients on this ward are afforded a greater degree of freedom and autonomy, with some of the women participating in part time work, education and the pursuance of hobbies and interests. At the same time, they will also benefit from continued participation in the New Dawn therapy program.

Admission

The normal procedure in order to determine suitability for admission is an initial request on our part for psychiatric reports, care plans and risk assessments from the referring team. Once these have been read and discussed by our multidisciplinary team, we decide whether or not to arrange a visit – free of charge – to assess the individual. This will be swiftly followed by a copy of our assessment and a letter either agreeing to or declining admission, accompanied by our reasoning.

Upon admission, all clients are introduced to their Named Nurse, given a tour of the ward and shown to their individual en-suite room which will have been prepared ahead of their arrival. As many of the women will be with us for some length of time, they are very much encouraged to make these rooms their own and are welcome to bring some furnishings and decorations of their own. All rooms have a TV socket and several power points.

As is the case with all wards at Bierley, New Dawn has a kitchen, dining room, TV lounge, quiet lounge, games/activities room, clinic room, courtyard, ward base and public telephone. It is our hope that this provided a homely, yet safe and secure environment in which to look after those entrusted to our care.

Shortly after admission, we ensure that the client has their rights (under the Mental Health Act) read to them and that they understand these. Should staff feel that they do not understand them in full, this will be regularly revisited as necessary. A Welcome Pack is also provided, which will help explain all elements of care and how the hospital and ward operate, so that they have a firm understanding of what to expect.

Authors:

Dr H Erlendsson Consultant Psychiatrist
Dr Kerry McHardy Associate Specialist
Siziwe Bhebhe Ward Manager

Stages of treatment

Even though we describe four distinct stages they overlap considerably.

Stage 1: This is the beginning of inpatient treatment. It starts with assessment and engagement. It includes treatment of various complicating factors such as psychosis, mood problems, eating disorders, attention difficulties, offending behaviour, alcohol and poly substance misuse. Another complicating factor is severe obesity and from the start we look at ways of managing this. We also screen for and manage other health issues such as hypothyroidism, obstructive apnoea and diabetes.

This stage usually lasts for three months but when the complexity is severe, it may take longer to treat the associated problems before they the individuals can engage fully in psychological treatments.

The first CPA after admission is arranged after three months, although this is not concrete and they will be held sooner if this is required. The CPA includes reports on the complexity of the case, prognosis and likely length of treatment we think may be necessary.

Although the majority of the clients admitted are subject to a section under the Mental Health Act 1997 we will also admit some informally, provided they are willing to actively participate in the program. However, it is important to note that those who are admitted informally often struggle initially and may discharge themselves early, which unfortunately undermines the help we are able to provide.

We usually make no changes to the medication during the first month, but then review medication depending on outcome of assessment. We start reducing benzodiazepines, hypnotics and opioids with the aim of stopping the individual throughout. We usually use mood stabilizers and opioid antagonists and omega three lipids and will treat adult ADHD with stimulants when necessary.

In conjunction with the clients, we write up care plans for each of their problems. Here, we aim to build a strong relationship between treating team – especially the named nurse – and the referring team, care coordinator and funder. We maintain regular contact with such individuals via phone and recognise the fact that clients with borderline personalities frequently manage to precipitate the breakdown of relationships of the people around them (professional and non-professional) and this effect needs to be openly acknowledged, discussed and managed.

Stage 2: This stage usually lasts for three to nine months and is the foundation of our psychological treatment. This primarily includes MBT (Mentalisation Based Treatment – Bateman & Fonegy) which is facilitated both through individual and group work. During this time we like to see the relationship with staff and peers growing stronger, encouraging the building of empathy for oneself and others. We seek to educate clients about borderline personality disorder and self-harm, focus on managing daily mood fluctuations and self-harm / suicidal urges. This is done through one to one sessions and community meetings, goal setting and chain analysis to learn from ongoing challenges on the ward.

We also educate about wound care. As the relationship and trust strengthens between the client and the staff team, we trust them more with regard to their own management of the risk of harm to self and others and give them more leave, both escorted and unescorted. This can sometimes lead to clients harming themselves more seriously or going absent without leave and must, therefore, be handled carefully through daily risk assessment and monthly multi disciplinary review of risk.

Often clients become very settled during this time. As a rule, after three months stability we consider rescinding the section in discussion with the home team. However, this can have an unsettling effect as the client takes on more responsibility and we recognise that this sometimes leads to increased risks and subsequent re-sectioning.

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Stage 3: As we see emotional skills improve and the client's ability improves in coping with daily stress, we then look towards more engagement in individual therapeutic work. This includes various techniques in therapy such as EMDR (Eye Movement Desensitization Reprocessing), Active Imagination, Body listening techniques, use of safe place, work with colour to describe emotions and perception of body, sculpture and art to communication feeling/mental state. Most of this leads to work on traumas from early life.

During this time clients can become more unsettled and there may be an escalation in self-harm or harm to other / damage to property. If they have become informal during this stage they may need a time on the section while going through the most difficult emotional experiences. The biggest challenge here is the management of risk, disengagement and early discharge.

When the risks reduce we like to see the client move to the open setting. This needs to be planned and the clients given plenty of time to adjust to this move. It is easy for some but very difficult for others, often related to the quality of the relationships they are able to develop. We try to manage this by using partly the same staff on both the wards. The transfer from secure to open setting usually has funding implications as the funding moves from Secure Care Commissioning to the Primary Care Trust.

When clients are transferred to the open setting this can lead to a period of instability and if they are informal, can lead to them taking early self-discharge. This leads to a high risk of relapse in the community. Even though their skills have improved, they may not be able to take on too many changes with out preparation.

Here the ongoing relationship between treating and referring team is essential. This stage usually lasts 3-9 months.

Stage 4: Here, the focus becomes moving onto the next step and usually lasts one to six months. Most clients, after discharge, will need some sort of supported accommodation. Many will require a 24 hour nursed setting, for a period of six to 12 months or perhaps longer. Understandably so, most clients are not keen on this after a long stay in hospital but without it, there is a much higher risk of early deterioration after discharge.

This is a prime opportunity to look at moving the individual to Bowling Ward, an open environment in which the clients are still able to participate in the New Dawn program, but are extended a greater degree of freedom and autonomy. However, this is not essential and many of the clients will remain on New Dawn. Whichever environment, we focus on various basic skills such as budgeting, education, cooking, group activities in the community, voluntary work and later paid employment as appropriate. As the move toward independence becomes more steady, clients are encouraged to self medicate and also begin planning for activities after discharge.

Here, the ongoing relationship between treating and referring team is paramount in order to facilitate smooth transfer to the community or supported accommodation. During this time we would like, if possible, to see more direct input from the referring team with the clients.

Should a client leave Bierley, it is anticipated that if placed in supported accommodation, the overall length of stay varies from 1 to 3 years depending on the client's needs, abilities and availability of local after care.

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Stage 5: Post discharge issues.

In general we would suggest that all medication remains the same for the first year and especially the during the first three months. We recommend a total of two years on Naltrexone and expect some difficulties for a month or so when it is stopped.

There are still issues about treating adults with ADHD even though the latest NICE guidelines have clearly stated that they recommend ongoing treatment. This is partly because such treatment is still unlicensed and also due to the fact that many clinicians are inexperienced in treating ADHD in adults. Methylphenidate does improve mood instability in clients with ADHD and helps them to cope with stress and to learn from experience. Hence, we strongly recommend that those who are discharged on it remain on treatment indefinitely, for one year post discharge as an absolute minimum.

Outcomes

The main outcomes we use are frequency and severity of self-harm and aggression (including damage to property) but we will also look at weight and weight stability where eating disorders play a significant role. In addition to this, there we also look at a substantial number of other areas which are not necessarily easy to quantify. These include:

- having ownership of their problems
- showing willingness to work with their own issues
- ability to cope with stress
- ability to show empathy
- ability to build relationships
- ability to manage their moods
- ability to mentalise about their own emotions and others
- frequency of emotional storms
- ability to work on conflict resolution
- ability to engage in trauma focused therapy
- shift from victim role to a sense of ownership and mastery

We provide monthly updates about medication, diagnosis, risk and engagement. As we are more focused on the process in engagement and ability to mentalise, we do not report as much on the information being processed or what are the key personal issues being worked on are, as these are discussed in our three monthly CPAs.

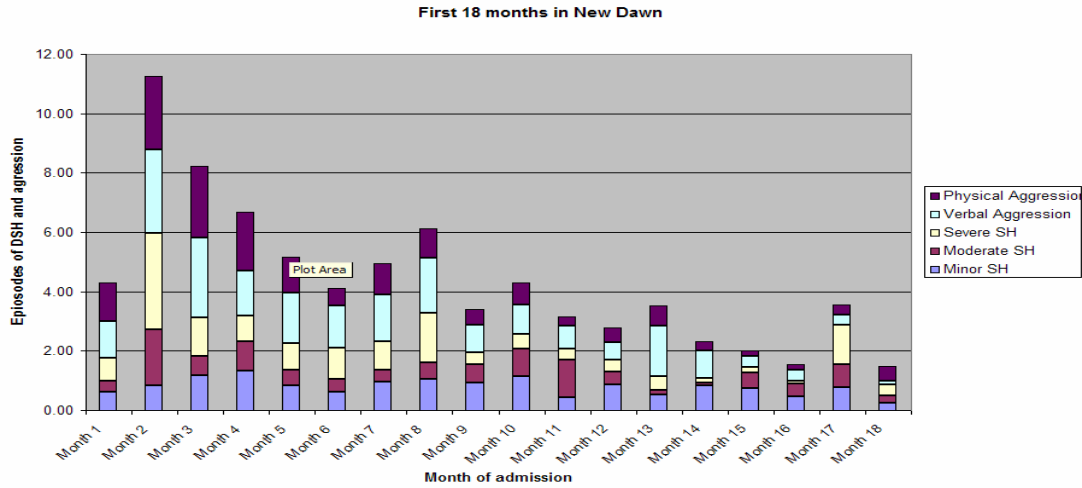
We feel it is very important not to disclose the delicate information about abuse or other traumas that is worked on in the trauma focused sessions, unless this is important for managing risk to self and others. Our therapists that deal with the trauma are seen as partly independent from the team and only communicate on issues about risk after therapeutic sessions. We find that our clients greatly appreciate this and it helps them to open up in therapy.

To our knowledge, no client has died from suicidal attempt or self-harm during admission or after discharge from New Dawn.

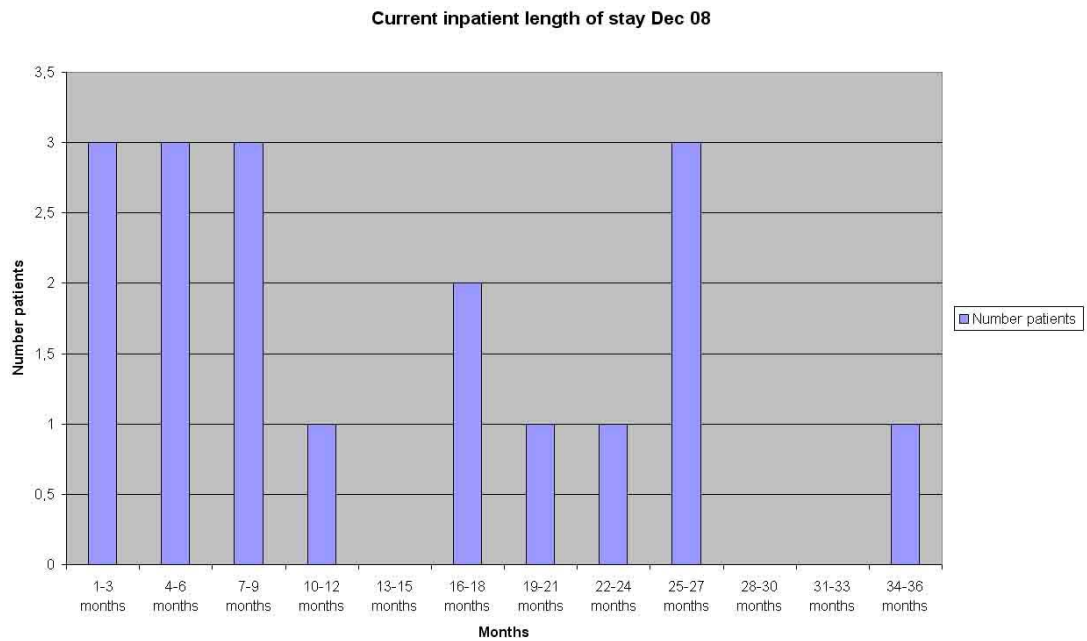
The table below is evidence how the frequency and severity of self-harm reduces over time, taking a snapshot from the point at which the service was initially established. The first month figures are low as the average length during the first month is 14 days and subsequently only shows about half the monthly figures of self-harm and aggression. In the first 18 months there is an 86% overall reduction in frequency of incidents.

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We have 15 secure beds and 8 open ward beds. In the thirty five months since we opened we have admitted 32 clients and discharged 14 clients.



Discharged Clients

Of the fourteen clients discharged from New Dawn (as of January 2009), four left during Stage 1, two in Stage 2, three in stage 3 and five completed their treatment with us.

STAGE ON DISCHARGE	NUMBER OF CLIENTS
1	4
2	2
3	3
4	5

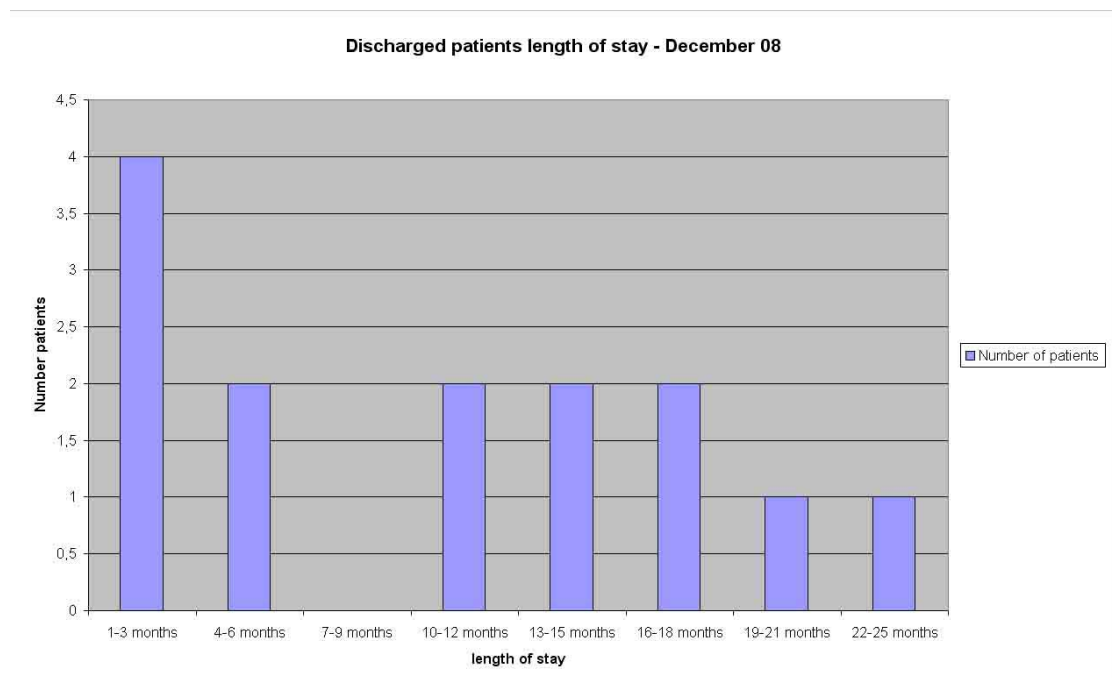
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The table below details where the clients were discharged to:

PLACE OF DISCHARGE	NUMBER OF CLIENTS
HOME	6
OTHER HOSPITAL	5
SUPPORTED ACCOMODATION	1
OTHER	2

The following chart shows the length of stay of discharged clients in December 2008.



We do hope this document has helped in providing you with a better understanding of our service. Should you wish to know more or have any questions regarding New Dawn, then do not hesitate in contacting Cygnet Hospital Bierley and asking to speak with Ward Manager Siziwe Bhebhe.

If you would like to discuss bed booking, contract discounts or Service Level Agreements, then please contact Hospital Manager Mark Fuller or Clinical Manager Sue Wroe., who will be happy to assist.

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