

The Tavistock and Portman NHS Trust

## ***Who we are... ...what we do***

The Tavistock Clinic

The Portman Clinic

The Tavistock and Portman is the leading NHS community mental health postgraduate training organisation. More than 120 professional staff - psychiatrists, psychologists, child psychotherapists, family therapists, nurses and social workers - provide training for 1200 students each year. The training is rooted in the broad range of psychotherapeutic and consultative clinical services across the whole lifespan, which we provide for our contracted purchasers in the North Thames region; some of our more specialised services are available more widely in the NHS. Each year around 3000 patients are seen in the clinics, with an annual average of around 47,000 attendances.

This booklet gives glimpses of the kinds of work we do, together with some of the services we are developing to meet changing mental health needs, and sets them in the context of our professional development during the last 75 years.

Alongside training and clinical services the Tavistock and Portman Trust is a centre of scholarship and research and many of the clinical trainees take higher degrees on the basis of their work here, awarded by one of several universities with whom we have close links: University College London, University of East London, Birkbeck College, Middlesex University and the University of Essex. There are also trainings outside London accredited by the Tavistock - in Birmingham, Oxford, Leeds, Nottingham, Liverpool and Bristol, as well as close links with trainings in two centres in Italy, in Zimbabwe, a possible new venture in South Africa, and courses set up by alumni in Spain, Australia, France, Brazil, and India. There are former trainees in all continents of the world. Each year the Trust puts on several major conferences related to our work and also launches around half a dozen books by clinical and research staff.

The Tavistock Clinic was founded in 1920 and the Portman in 1933. The two clinics became the Tavistock and Portman NHS Trust in 1994.

If you would like to know more about our clinical services and how to access them, or would like to receive a copy of our prospectus of training, or have information about our consultancy services, please contact:

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### Multidisciplinary work in the community

We hear about 'care in the community', but what is it? The old psychiatric asylums have all but closed down, and although a few patients have lost their only secure base, most agree that a life in the community is better, provided there is appropriate support. The trouble is that this support is not always available, or if it is, it is not always sufficiently skilled. The transfer of many mental health responsibilities from the NHS to local authorities puts enormous pressure on hard pressed social services.

One of the primary goals of the Tavistock Clinic is to develop methods of psychological support. The care programme approach of modern mental health services requires far greater flexibility than the old hierarchical psychiatric system, where staff were meant to do what they were told. Yet the new methods bring their own problems. Who is responsible for what? Who is in charge? How far does a key worker's responsibility go? These are questions that have to be discussed in each new case. Team members have to learn to use their own authority, rather than rely simply on a senior figure to provide instructions.

We train health and social work professionals to support front-line colleagues in the community, but we also train some of the community workers themselves. As innumerable inquiries and reports have shown, communication between different workers, both within and between agencies, is crucial. From long experience in studying groups at work we know that this is no simple matter. Professional people are not immune to rivalry, blaming, and other very powerful processes that can overwhelm a group's capacity for work. The sharing and negotiation of responsibilities is every bit as important in mental health as it is in business or any other enterprise. Community mental health work is not a task that can be managed by single-handed individuals.

Many patients with mental health problems will have relatives - parents, spouses and children - who are bound to be affected by these problems. Our model of mental pain is one that inevitably connects one person's distress to others, especially those who are close, and it is therefore not possible to think of the patient in isolation, even if he or she is seen alone. There is always a context, and always a need for several points of view in making an assessment of the problems. This may seem extravagant, but we have to respect the complexity of conditions which may have been building up for a whole lifetime, or indeed that originated in a previous generation. Therapeutic help can change the course of people's lives, even if some difficulties and anxieties inevitably remain. Mental disorders do not come in tidy packages. In any case teamwork for outpatient care is considerably less costly than residential treatment.

The origins and development of the Tavistock Clinic after the first world war

In the first annual report of the Tavistock in 1920 Dr Hugh Crichton Miller the Director wrote:

“The medical profession suffers from the tacit convention that its business is to cure a diseased condition of the body. Our avowed aim is to investigate, and if possible to remedy, disabilities of the personality as a whole. If a man contemplates suicide it is of little use to assure him that he is free from organic disease. He has found that life is not worth living; it is our business to find out why, and if possible to make him feel that life is worth living. If a woman complains of numerous and vague pains which have driven her to the out-patient departments of half the hospitals in London, it is not enough to assure her that her pains are all imaginary. An imaginary disease is a disease of the imagination, and as such may be just as disabling as a disease of the heart or lungs. It is our business to find out why her imagination continues to generate such unpleasant and crippling sensations. Similarly if a child of 12 is referred to us by the headmaster of his school for persistent pilfering, it is futile to say, ‘Stealing is an anti-social act; he must learn the consequences of his actions; let him have a good caning or be handed over to the police; that will teach him a lesson he will not forget.’ But will it? Our attitude is that a reason must be found to explain why this particular boy should need such drastic penal treatment. What is it in his personality that makes him incapable of assimilating the usual lessons of honesty? If we can find out the answer to that question we may possibly save the community from having on its hands in years to come one more incorrigible criminal.”

This was written in the aftermath of the first world war in which many men were permanently scarred by the brutality of battle. This spurred on our understanding of emotional trauma: “shell shock”. It was not a subject which appealed to many doctors; or to many people in high places. It took the visionary work of Hugh Crichton-Miller to make people appreciate that this disorder should be treated constructively and with sympathy. In 1920 he opened a clinic in Tavistock Square - hence the name - and visualised it as a place where people who were struggling to hold on to their work could find understanding. He continually stressed the importance of respect due to even the most foolish of patients. Disturbed people were to be viewed as products of their environment and of their history, rather than dismissed as weaklings or cowards.

Between 1932 and 1939 there were major advances in treatment, training, external lecture courses and considerable growth in the number of staff and trainees. Many alumni came to occupy leading positions in psychiatry and child guidance in the UK and overseas. The Tavistock moved to Hampstead during World War II and the

greater part of the Clinic's professional staff joined the armed services as psychiatric specialists. From their work arose a whole new area of interest in staff selection, notably the war office selection boards - the basis of much present day personnel work. The war-time experiences they encountered were to influence the Clinic for the remainder of the century.

In July 1948, along with nearly all other voluntary hospitals in the country the Tavistock became part of the NHS. The clinic moved to its present location in 1967.

In the post-war period Tavistock research and development radically altered several aspects of medical practice. The work of Dr Michael Balint, defined in his seminal work 'The Doctor, The Patient and The Illness', threw new light on the complexity of the relationship between the GP and the patient. His insights have had a significant effect on GP training and practice. Research by Dr John Bowlby and his colleagues at the Clinic completely reversed the attitudes to parental visits and children in hospital that were prevalent up to the nineteen fifties. A now famous film (A two year old goes to hospital, Concord Films, Ipswich, 1952) shot by James Robertson in 8mm black and white without sound or special lighting, showed conclusively that those children considered 'easy' patients, apparently not needing their parents, were in fact in despair about being abandoned by them. That particular Tavistock research has completely changed hospital attitudes, and transformed child care. Bowlby's attachment theory, regarded by many as amongst the most important work in developmental psychology since the war, has led to an enormous volume of research on the lives of infants and young families, which has extended our understanding not only of mental disorder but also of the conditions that lead to personal and social competence in adult life. These ideas are now part of the fabric of health and social policy. Although he retired from the NHS in 1972, Bowlby worked at the Tavistock Clinic continuously from 1946 until his death in 1990, aged 83.

From related Tavistock work in perinatal bereavement, the experience of stillbirth in hospital is now understood and handled very differently. Tavistock work highlighted the need to provide opportunities for the parents to mourn, and co-operative work with nurses and obstetricians has led to new forms of support.

The Portman Clinic: The Portman's origins lie in a report to the Medical Research Council by one of its co-founders, Dr Grace Pailthorpe. She was concerned with 'what we put in prison'. The Clinic was founded in 1933. at a time when new ideas about the psychological and psychoanalytical treatment of offenders were arousing interest and enthusiasm on both sides of the Atlantic. This new energy resulted in the formation of the Association for the Scientific Treatment of Delinquency. The clinical part of the association (which later became the Institute for the Study of Treatment of Delinquency) opened as the 'Psychopathic Clinic' for the outpatient

treatment of offender patients. By 1949 it was called the Portman Clinic from its original location in London's Portman Square, and had joined the NHS. The clinic moved to its present location - quite by chance next to the Tavistock - in 1970.

### ***Young People's Counselling Service: YPCS***

“People between the ages of 16 and 30 can refer themselves to the Young People's Counselling Service - they like it because it is free, non-threatening, secure, and there is no bureaucracy.

A 22 year old electrician calls the YPCS. He recently divorced and has a three year old child whom he misses desperately. He can't understand why his wife doesn't love him any more. He is in a pub, someone jogs his arm and spills his drink. The next thing he knows he has knocked the man out and is under arrest for affray. Never before in his life has he been in a fight. He calls the clinic because he feels frightened about the potential effect of his anger and aggression. He will not talk to his ex-wife because he has difficulty in articulating his feelings. In a few sessions with a psychotherapist he expresses his rage and despair, which stems not only from the divorce but also from a sense of being unwanted in childhood. This is the first time in his life that he has found words for these feelings, yet they have influenced his life in important ways, including his choice of marital partner.

Most callers know instinctively what the problem is but they do not always have the language with which to express it. If they are given the words, they become increasingly able to think about the situation and remove some of the anxiety.

They make up their own minds to call us. A counsellor will see them within two weeks and will offer them a further four sessions. Adolescence presents milestones which have to be negotiated - moves from school to work or college, from home to a more independent lifestyle, and to adult sexual and marital relationships. We provide a space somewhere between the formalised world of the caring professions and the concern of the ordinary citizen who wants to know what counselling is like before making any commitment.

We are often called because the young client has suffered a bereavement, or even the anniversary of a bereavement. He may not have any idea why he is feeling so awful. Clients can experience enormous anxiety at the first meeting and much of our initial work is spent in uncovering what it was that prompted them to come here.

This is a service which requires a great amount of experience on the part of the counsellors. Around a hundred young people make use of this service each year. The majority are helped to find ways of thinking about emotional life, rather than simply reacting to it.

## ***Family therapy***

A family can be understood as a 'system' of interacting family members. By helping people to change the way they relate to each other, symptoms and problems can be resolved.

A close-knit family was referred because the fifteen year old daughter was suffering from repeated headaches. She was unable to go to school. Parents, daughter and younger brother attended five sessions over a period of three months during which a family therapist helped create a safe environment in which family members could talk together about their worries. Both parents were able to share their concerns about their children growing up and being more involved with their peer groups. The daughter and her brother spoke about their problems fitting in with their friends because they didn't want to hurt their parents.

By being able to talk about these things openly each family member could appreciate the other's position, and then work together toward tackling the problem. The family agreed to further meetings to discuss the parents feelings about letting go of the children and their children's strategies for making friends, without creating undue stress for the parents. The daughter was also asked to keep a chart of her headaches. She now attends school four days a week although she still gets occasional headaches.

The systems teams are based in the Child and Family department of the Tavistock clinic, and provide, alongside treatment for scores of families each year, one of the most prestigious career trainings in the country. Family therapy is provided by teams of three or four trainees with one staff member. Sometimes work may be done with a part of the family, such as the parents alone.

The systems, or systemic, model originated in the 1950s and 60s as an alternative to psychoanalytic methods of the time, and it has developed new ways of working which can reach some families, for example those in which the children are out of control, that could not previously be helped by psychotherapy. During this time psychoanalytical psychotherapy has also extended its range and both approaches work side by side in the clinic.

## ***Tavistock Mulberry Bush Day Unit***

Children referred to the day unit are representative of those with the most severe levels of psychiatric disturbance in combination with either specific disorders of psychological development, or more global learning disability. They have often exhausted the resources of their Local Education Authorities. They may have

presented particularly challenging behaviour to their teachers and carers, or may have failed to make any educational progress over a substantial period of time. These children usually also have extreme difficulties in making or maintaining peer relationships. Their relationships may be characterised by violence and aggression, or perhaps more worryingly by solitariness and withdrawal, and the rebuttal of any social overtures from other children. They are often either the bullies or the bullied. Although bold attempts may have been made to work with parents and carers, the relationship between school and family is often close to breakdown at the point of referral.

The Tavistock Mulberry Bush Day Unit has 18 places for primary school-aged children, and offers detailed educational and clinical assessment of the child in conjunction with an assessment of family functioning. It is a non-maintained special school which accepts referrals of children with Statements of Special Educational Needs from Local Education Authorities. The Unit is staffed by an educational team and by a clinical team, which comprises educational psychologist, psychiatrist, child psychotherapist, social worker and speech and language therapist. Visiting professionals include a neurodevelopmental paediatrician and other therapists.

If offered a place, most children will remain at the Unit for between one and three years. The aims during that time are to promote their learning and emotional development, and to help their carers both to understand the nature of their difficulties and to provide a more optimally nurturing environment for them. We believe in the value of helping children in adverse situations “to learn to learn”, thereby providing them with particular skills to draw upon in future years. The educational component of the Unit’s intervention is therefore seen as a critical component of an overall package which encompasses a range of treatment approaches matched to the needs of each child and family.

Besides a focus on the individual child, treatment also incorporates work with parents or carers, and networking with the wider system, which often includes Social Services as well as the Local Education Authority. Regular reviews, both statutory and in-house, contribute to the process of audit, of our work generally and in relation to the aims and objectives of each child and family’s particular treatment package.

### **Research**

The Tavistock and Portman Trust is a centre for the development of professional mental health practice and research

Public suspicion of a culture which proclaims that counselling and therapy are the panaceas of the 20th Century are well founded. We have to be more discriminating. It is also not just a simple matter of the whether there is scientific evidence for this approach. Good evidence can be ignored and poor evidence can be overvalued.

In the new health service there is far greater pressure on resources than in the past, and the public demand higher standards of care than they did in more deferential times. The Tavistock and Portman Clinics are proud of their tradition of attentive clinical work. Psychotherapeutic consultations and treatment are not applied according to protocols or instructions. We have to find out carefully how the patients themselves view the problem. There is increasing public and scientific recognition that clinical work which is not respectful of individual differences is unacceptable, whatever the nature of the treatment being offered.

In the past decade the academic and research work in the Tavistock and Portman Clinics has grown enormously. There are now three professors, in developmental psychopathology, child and family mental health and social work, and besides their internationally known work there are many clinicians, most of whom also have honorary academic positions, involved in studies of clinical and theoretical importance. For example, there are currently studies underway into the nature and treatment of autism, sexual abuse, the effects of physical illness on families, the effects of divorce, and cultural variations in parenting styles, amongst many others.

Common to all these studies is the view that life experience, especially in infancy, has a profound effect on the later capacity for satisfying relationships and rewarding work. Our research builds on, and contributes to, other studies from the universities with whom we are linked. Increasing numbers of our trainees are taking higher degrees, putting ever greater demands on the Tavistock Library, recognised as one of the finest of its kind in the country. There is increasing research evidence to show the importance of relatedness, both personal and therapeutic, in mental health and social functioning.

Alongside the rapid growth in research the clinics have put resources into quality assurance and audit. Besides projects examining the outcome and quality of particular services and procedures, a major consultation exercise into equal opportunities practices has just been undertaken. This is expected to result in a recruitment drive for greater representation of ethnic minorities amongst both staff and trainees.

The majority of patients and families who consult the clinic are helped by the experience. Even with the welcome growth of relevant systematic research in

psychotherapy, it will always be necessary also to rely on the judgment of individual patients and clinicians in assessing the value of our work.

The Adult Department provides a psychotherapy service for some of the most troubled patients. Because they are not hospitalised it is sometimes assumed that such individuals have relatively minor problems in living; this is far from the case.

A man of 50 was referred to the Adult Department for depression by his GP. As a baby he was in hospital for several months with a life threatening illness. His father died while he was young and he cannot remember him. His mother was depressed and cried a lot. He spend his childhood staying out of the house on the streets. In his early teens his mother made him sleep in bed with her for comfort. He frequently truanted from school and left at 15 to earn a living. He eventually settled to work as a semi-skilled worker on a building site. His life since then has been interrupted by periods of depression when he couldn't work. He feels he has serious sexual inadequacies which have left him unable to sustain a relationship with a woman for more than a few years. His inner pain has been relieved only by drink. Twice he tried to kill himself. He has attempted to better himself and has managed to obtain an OU degree, but anything else he has attempted has been sabotaged by his virulent self hatred. He lives on his own, finding company whenever he can, and lives with constant anxiety about himself. In his middle age he can see no worthwhile future.

Every referral to the Adult Department of the Clinic brings to light the pain of severely restricted lives. In general psychiatry many patients have similar histories to tell, but the range of adaptation to real life would vary considerably. Some will totally turn away from reality, as in schizophrenia or psychotic illness, while others manage to make a reasonable life. The range in between covers violence to self and others, serious delinquency, addictions, and all kinds of disturbances and confusions in mental state. As human beings we are dependent on our minds. Will power or conscious intent is not of itself much help when faced with such force.

The clinical approach of the Adult Department is based on trying to bridge the gaps in a person's mind through understanding the detailed way in which a person's character fits together with their past, their environment, and their behaviour, so that they can begin to think for themselves. A psychotherapist listens sympathetically without judging and attends to the person's difficulties in facing reality with its attendant sadness and pain. After eighteen months of twice-weekly 50 minute therapy sessions, the patient whose story appears above was beginning to feel greater respect for himself, and to make closer contact with others. Such progress seems slow, but it entails working through a lifetime of misery and neglect. It is

unlikely that any other form of treatment would be able to achieve even these modest, but lasting gains. His therapy continues.

The Adult Department provides a treatment service for individuals, both in one-to-one psychotherapy and in groups. It also has a marital therapy unit. It trains professionals from the various mental health disciplines to practice psycho-analytic psychotherapy to the highest standards. It runs courses for many others to develop skills as counsellors, social workers, probation officers, nurses, and psychologists in which psychoanalytic experience is applied to more general roles. There is a Research Unit to advance the scientific knowledge base of mental health.

\_Help for the adult survivors of traumatic events is offered by the Unit for the Study of Trauma and Its Aftermath.

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Kings Cross, Lockerbie, Dunblane.....

The names are familiar because of their association with major disasters. These events receive much attention in the media, but other more private disasters befall people daily, like the car accidents and muggings that may receive a line or two in the local paper.

A 35 year old man, working as a security guard, was seen following his being caught up in a robbery in which he was bound and held at gunpoint for several hours.. He was experiencing nightmares and flashbacks, was irritable at home with his wife and children, afraid to go outside his own house, and unable to work. During the course of a therapeutic consultation with one of the Unit staff, he was able to begin to talk openly about the event, particularly his terror that he might have died that night. He also understood that his continuing anxiety was partly the result of inhibiting his own rage about what had happened. It emerged that he was terrified of his own murderous feelings, and the cultural and family prohibitions against such emotions. By the end of the consultation he had talked with greater freedom about the event, and about himself and his history. From this, he was able to understand more about the particular way he had reacted to this dreadful experience. He felt more able to express his feelings, and less anxious about engaging with life. He went back to work, in a different job.

People referred to the Unit are usually seen within 3-4 weeks by one of our specialist psychotherapists who can offer a consultation of up to four sessions. This offers the opportunity to talk about and understand the impact of the event, integrating it in a way that can modify its potential for ongoing, crippling effects. Further help, usually in therapeutic groups, is also available for those needing something more following the consultation.

The Unit offers teaching and consultation for other professionals in the field.

The Portman Clinic is one of the few clinics in the world that treats criminals and sexual deviants as out-patients. The Portman influences prisons, probation, forensic psychiatrists and social workers in ways of dealing with criminality.

The Portman deals with patients who have either indulged in an act of criminality or who see themselves as suffering from a sexual deviation. We might see a man who is just about to be discharged from prison for manslaughter; a woman with a history of thirty or more convictions for burglary and theft; a man so addicted to pornography that it dominates his life to the extent that he is unable to work. Patients come to the Portman because they are provided with a confidential and uncritical relationship. This fact is fundamental to our success. Patients with histories of criminality come either before or during trial or on release from prison.

We regularly work with the judiciary because judges are keen to understand why someone has committed a crime and whether or not a person is amenable to treatment.

One of the purposes of the Clinic is to try and understand what it is that makes one person indulge in sexual deviancy and another not. There is a very strong compulsive element in what the patients do. This may provide brief moments of excitement in lives which are otherwise plagued by the threat of depression, or even suicide. We support this particular group of people without actually condoning what they have done. We help patients to control their fantasies and modify their need to act them out. A high proportion of our clientèle have histories of sexual abuse, and a higher proportion still have suffered from inconsistent parenting and institutional care.

Our influence is far greater than the number of patients we see. We also advise and support other professions towards ways of dealing with criminality. The Portman Clinic has built up a body of knowledge which is disseminated to other services. Besides the judiciary, we work with the courts, the prison and probation services, forensic psychiatrists and social workers.

Care in the community - new models of work for community psychiatric nurses  
Community Psychiatric Nurses are happy to go into the community where they can be relatively independent. However working face to face with patients in that community is much more difficult than working in a ward - the ward provides support. When they meet a lack of support from GPs or psychiatrists, Community

Psychiatric Nurses often find they are unable to cope. They may tend to act as counsellors to the less ill people without knowing what to do with the severely disturbed. There is an urgent need for an advanced training program to help them remain in role, and offer effective help to the most ill patients.

There is a widespread perception of crisis in mental health services at present. This is partly due to shortage of resources - beds and staff - but there is also a lack of suitable training for nurses and others, including GPs and even psychiatrists. Besides supervised psychotherapy with individual patients, group therapy - practised every day at the Tavistock - is a valuable therapeutic tool for nurses in general psychiatric settings. We also have a long tradition of experiential group relations training that helps to give the worker the capacity to keep his or her head in highly stressful environments such as a ward or community home. These are essential conditions for humane and thoughtful care.

We train future leaders who can in turn apply these ideas and train others. Consequently we have now launched a Diploma/Masters course, in collaboration with Middlesex University, and began in the Autumn of 1996. The course aims to be an integrated and comprehensive provision specifically for nurses and social workers. Other short courses and conferences will follow.

### ***Post divorce work with parents and families***

It is hard for divorcing parents to equate making their own lives better with the possibility that their children's lives might be made worse.

A mother consulted us about her eight year old boy who was presenting severe behavioural problems at school. He had already changed schools four times. The parents were in the middle of a bitter divorce and there were vicious rows between them. An opportunity for the couple to talk about the needs of the child, to think about how to be parents to him, even if the marriage had to end, brought about improvement in the child's behaviour. Contact with the school made it possible for him to remain there until his transfer to secondary school. The boy now sees his father regularly and discussions about his wellbeing are taking place between the parents.

Many children referred to the Tavistock Child and Family Department have been caught in really unpleasant divorces. We try and work with all the possible combinations of the relationship. We see children with the parent who is currently looking after them, and we also see the parent who doesn't look after them but with whom they have contact. We see the children on their own so they have the chance to tell their own story. Where possible we see the parents together and try to get

them to focus on joint parental responsibilities even though they are no longer marital partners.

As divorce figures climb, further research is needed in this area. We need to help parents find the best way to parent their children after separation. Disturbing statistics show that 50% of all fathers lose contact with their children in the second year following divorce. Both research and clinical experience shows that reduction of conflict and 'free and easy' access to both parents are beneficial for children. Our service endeavours to provide parents with a space to think constructively about their children's needs.

### ***Service for refugees***

Most of us are deeply affected by the media coverage of the plight of refugees. But for many of those seeking asylum in the UK, their troubles are far from over.

Munira was born in a refugee camp in the Horn of Africa. By the time she was fourteen years old she was alone having lost her parents and siblings. An aunt, living in another country arranged for her to come to the UK to find an unknown uncle. Munira arrived in London clutching only her uncle's disconnected telephone number. As she stepped out of the plane on a freezing January morning, she was alarmed to find that 'smoke was coming out of her mouth'.

In transit she had become acquainted with a woman who befriended her. On arrival in London this woman took her home, bought her warm clothes and contacted Social Services. Munira expressed a wish to live with a family but as she was now fifteen this option was not available to her. She was taken to a bed and breakfast and given £25 for food. Her second wish was to go to school and she was enrolled locally. She had never been to school before.

For a number of years the Clinic has been running an Outreach Counselling Service for refugee children in a local school where 15% of the pupils are refugees. For these youngsters school often comes to represent a substitute home and family. This is particularly so for those, who like Munira, arrive here unaccompanied.

Not surprisingly, the teachers found Munira's tears difficult to bear and they worked hard to cheer her up and keep her busy. They helped in whatever ways they could including referring her to one of the Counsellors. Like many of her asylum seeking peers, she had quickly picked up sufficient English to express an interest in this referral. Indeed, English was Munira's third language.

The aim of the counselling is to provide these traumatised young people with an adult who can sit quietly with them in their grief and bear to feel as impotent as they themselves do. Their feelings of hopelessness and despair, frustration and anger are talked about and links made between the past and the present.

The asylum seeking and refugee children and families who approach The Child and Family Department for help come from a range of countries including Ethiopia, Somali, Zaire, Iraq and former Yugoslavia. Often they express concern about their children who are having difficulty in sleeping, in learning or with their behaviour. The adults can find it hard to understand why it is, that having reached physical safety, they are unable to put their memories of violence and terror behind them. For these families we provide a space in which these difficulties can be thought about and understood.

Staff working with refugees have a particularly painful and disturbing task as the experienced trauma is often powerfully recreated in the interview room. This re-enactment is in part an attempt to gain mastery over an experience which although actually survived continues to feel overwhelming. Given the intensity of this work, staff themselves require support in order to restore their equilibrium.

In recent years, the Government has expressed concern about the high rate of suicide within refugee communities and has identified the mental health of refugees as an area of priority. The Child and Family Department addresses these issues at a number of levels. A research project on the needs of Bosnian Medical Evacuees is underway. Training, Supervision and Consultancy is available to those from both the voluntary and statutory sectors, who are working in this field. Clinical Services are available within the Department. The Outreach Counselling Service within community is currently being extended.

### ***Learning disability service***

The Tavistock has a specialist service for people with learning difficulties.

The Tavistock Clinic has a service for people of all ages with learning disability - children, adolescents and adults. It provide assessments and treatment for those with learning disability who also have emotional problems.

Many people with learning disability will never need our service. Those with emotional problems may respond to a psychotherapeutic approach, and these will become our patients. They may have problems with interpersonal relationships, stealing, uncontrollable anger, self-injurious behaviour, depression, disturbed family relationships or abuse, sleeping and eating problems, or bereavement. There may

also be questions about further education, of fostering and adoption, parenting, and developmental issues around adolescence. Therapeutic work can be undertaken with individuals, in groups, with parents or carers alone, or with the family as a whole. The team also offer consultations, on a regular basis if need be, to other professionals involved in work with learning disabled people.

### ***Primary Care at the Tavistock***

GPs often say that mental health professionals don't appreciate what the real world is like. Two GPs on the Tavistock staff still run their surgeries, while helping the clinic re-assess both the referral process and the professional relationship.

The Tavistock has a long history of working with GPs. Fundholding, and the new emphasis on primary care have moved GPs into a more powerful position as principal stakeholders in the NHS.

The remit of the GPs at the Tavistock is threefold. They are developing training programmes for GPs in order for them to address more effectively all the psychosocial issues they are likely to face - mental health issues, family issues, wider social issues.

Their second remit is to challenge the various professions in the Trust and get them to consider how referrals arise and why. Referrals come to the clinics from a variety of sources, from GPs, social workers, teachers, probation officers, parents and, in the case of the Young People's Counselling Service, from young people themselves. There are several questions to be asked. Is the clinic getting a representative sample of referrals? Are those being seen selected by appropriate criteria? How is the relationship with the referrer fostered and continued?

And thirdly we want to stimulate new thinking and new dialogue about the domain of General Practice. Medical training is long and intensive, and the work of GPs is subject to ever increasing pressures. Many of them find themselves dealing more and more with patients whose illnesses have a mental health dimension.

We understand how human beings work together or fail to work together. This expertise can be relevant to multinational enterprises as much as to human service organisations.

The Tavistock Clinic Consultancy Service is designed to enable chief executives of organisations, managers, teams and groups within organisations both in the public and private sector to understand and work better with what goes on 'below the surface'. This is our reference to the unconscious - we are aware that psychoanalytic language is jargon to most people, and therefore impenetrable. Conflict is inevitable in the work-place, and we work with it using ordinary language.

The organisations that will be really effective in the future will be those that manage the human dimension well. Our involvement may vary from a series of individual consultations with the chief executive to an extensive programme of organisational change, to specialised training workshops.

The consultancy service is designed to enable senior managers and chief executives to understand and work with psychological processes that are operating below the surface in their organisations so that they can:

- \_ develop their staff
- \_ understand the hidden dynamics of their organisation
- \_ work with the human dimension in the work place
- \_ develop creative solutions to organisational dilemmas
- \_ reduce internal tensions and improve communication
- \_ enhance their exercise of strategic leadership

In providing this service we are making a contribution to the nation's health by promoting better working practice, thereby reducing stress and the possibility of additional calls on the nation's mental health costs.

The Tavistock Clinic is a major postgraduate training institution for mental health and social services. Twelve hundred qualified and experienced people from a wide range of professions make up the annual student body. Many of our courses are oversubscribed

### ***Multidisciplinary training***

The Tavistock has always based its teaching on a multidisciplinary style of work. A team will always have psychiatrists, psychologists, psychotherapists and social workers present. As just one example, a one year, half day a week course on Therapeutic Communication with Children will contain social workers, play therapists, nursery workers, art therapists, children's nurses - all sorts of people who are hands on workers with children in institutions of one kind or another.

We are one of the largest career trainers of child and adolescent psychiatrists in the country; and are by far the largest trainer of child psychotherapists. These courses run over several years, extended further if part time. The intensive training in adult psychotherapy is one of the best known courses, which includes training for qualified psychiatrists who want to become psychiatric consultants in psychotherapy.

Besides a dozen career trainings, there are a over thirty part time or evening courses which provide extension and enrichment to the professional work of a broad range of people who may often feel that they are no longer adequately equipped for the more specialist work which they find themselves doing.

We are contracted to the NHS to provide an extensive programme of post-graduate training to mental health professionals. That training - and also the development work and research which supports it - is rooted in our clinical work for health authorities in North London. We believe that people emerge from the Tavistock with a broader base of clinical and management skills than is available elsewhere.