CONTAINMENT IN THE COMMUNITY

Supportive Frameworks for Thinking about Antisocial Behaviour and Mental Health

Edited by
ALLA RUBITEL AND DAVID REISS

The Portman Papers

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Alla Rubitel and David Reiss
London
January 2011

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PREFACE

Alla Rubitel and David Reiss

We developed the concept of this book when we were both working together at a medium secure psychiatric unit as a senior trainee (specialist registrar) in forensic psychotherapy (AR) and a consultant forensic psychiatrist (DR). Our work included the provision of outreach support and links to a variety of mental health and criminal justice system community settings. In all these environments, we were struck by the complexity of the psychopathology of the patients, as well as their high level of clinical and social need. We experienced at first hand how working with this population has powerful effects on all involved in frontline care and management. While there are a variety of existing structures designed to support professionals in their attempts to process these forces, both their provision and uptake is patchy. We noticed that many of these institutions, instead of providing space for thought and reflection, have various risk policies. Although these documents may contribute to a helpful framework of care, if used in isolation they can create a superficial illusion that safety and security is being attended to effectively, where this is actually deficient.

We have been particularly interested to observe and try to understand how a combination of mental illness and offending

behaviour has an impact not only on our patients, but also the staff looking after them. The latter, when faced with the patients' difficulties in a relatively close relationship, which is intended to be therapeutic, often develop strong defences. Experienced and well-trained staff in apparently well-supported high and medium security inpatient settings may experience "burn out", which can result in difficulties such as extended sick leave, or an apparent "blind and deaf" response to the risks that patients present.

The high walls of secure institutions are only able to contain temporarily the anxiety about reoffending risk carried by both the community and mentally disturbed individuals themselves. Moving on from hospital into less secure community settings, both staff and patients leave behind the real physical barriers which served psychologically to lock anxieties out, protecting the patients from their unconscious fears that they will reoffend, as well as damping down the more conscious fears of the public. The latter have been at least partially addressed in England and Wales through the Multi-Agency Public Protection Arrangements, described in this volume by Jessica Yakeley and Richard Taylor, designed to increase co-operation between various community agencies dealing with offenders, including those with mental disorder.

Staff resources and skills to support the task of rehabilitation appear scarce outside the walls in comparison to within high and medium security hospital units. Yet, the individual forensic patient's needs are still very high: they require intense rehabilitation, as well as pharmacological treatment to prevent a relapse if they are mentally ill. Professionals commonly experience anxiety and tension when delivering this complex task, an issue explored by Alla Rubitel, who describes how staff members manage to work with chronically mentally ill offender patients in a forensic hostel. The provision of support to such settings is also discussed in the chapter by Jina Barrett. Caring staff in such institutions not infrequently experience potentially very risky situations, which have to be dealt with in a much less structured and supported environment than pertains in secure hospital units. There may also be less expertise available in such settings, except in highly specialized services, which can lead to difficulties with teamwork, with problems such as excessive anxiety and splitting, as reflected in Rosemary Richard's essay about how a homicidal adolescent was managed in the community.

Although many general psychiatric teams are willing and able to look after complex, risky patients, some services express concern about their capacity to assess and manage them. As a consequence, the latter teams may be reluctant to engage with mentally ill offender patients, perhaps frightened of the consequences if things go wrong. They might believe that they are unable to deal with such cases in the absence of sufficient back-up, for example by forensic colleagues, or because they perceive they might lack appropriate internal resources. Richard Taylor explores the area of the interface between general and forensic psychiatric services.

Some individuals in the community have antisocial and borderline personality disorder traits, but their level of perceived dangerousness is not high enough, and offences committed already are not grave enough, to be deemed to require the routine attention of forensic psychiatrists. At different stages of their lives, they may be perceived as too risky, not sufficiently psychotic, and too difficult to engage by general psychiatrists and/or therapeutic communities. However, they may pose a significant and continuing threat with regard to potential violent acting out behaviour that may well warrant care by the multi-disciplinary team. Some mental healthcare teams may not consider these individuals to be their patients at all; others may view them as priority patients, or they may be seen as patients that nobody can deal with. They might be picked up by forensic teams as a gesture of goodwill without community resources available to look after them, or general psychiatrists may attempt to provide a cohesive treatment plan to individuals who apparently do not want to be patients. These risky and vulnerable individuals crop up in different statutory and non-statutory services at various times, often falling into the cracks between fragmented services. They may be accepted and discharged again just after or before they create another episode of disturbance. Rob Hale looks at these issues in his chapter on personality disordered offenders, highlighting the diagnostic value of the staff's emotional responses. There is clearly something amiss for these service users to act the way they do: attention and understanding is needed to find meaning in what may appear to be meaningless acts.

Mentally ill adults and adolescents who behave in antisocial ways, and those with abnormal personality traits, become well known to services through the amount of action, frequently not

allowing much space for thought, that develops around them. Professional carers in community settings need to find ways of understanding and engaging with these individuals, which should involve responding appropriately rather than knee-jerk reacting to the disturbance. They may be seen as projecting their inner chaos outside themselves in the unconscious hope that they will be free of it, yet, in the process, generating a new external disturbance. Society and its community facilities may attempt to get rid of the unwanted problem in a similar fashion by expelling these difficult individuals and the disorder they stand for into more secure places. Will Crouch and Mike Solomon, respectively, consider these issues, and illustrate them with vignettes. John Adlam and Chris Scanlon reflect on how, to be able to be effective with the antisocial and marginalized, the teams involved have to be able to think about not only who and what they are dealing with, but also their own responses to antisocial individuals or those who are at risk of becoming them.

Psychoanalytical thinking can help us understand these issues, starting from the concept of the unconscious, contributed by Freud. Melanie Klein subsequently elaborated theories of projective identification and unconscious fantasy. Bion subsequently developed our understanding of the container–contained concept, as well as group processes. These ideas were expanded and applied to institutional dynamics by Isobel Menzies Lyth, Tom Main, R. D. Hinshelwood, and many important others. They described defensive manoeuvres which deal with unbearable anxieties about change in organizations as well as staff contact with patients. However, it is not the remit of this book to focus on the history of these developments, although we acknowledge them.

The contributors to this volume make reference to the psychoanalytical literature throughout, yet we have asked them to refrain from using complex language wherever possible, in the interest of bringing these ideas to a broad readership. We hope that you will fully understand the psychoanalytical concepts as illustrated by the case examples given, without the use of unnecessary jargon. Most of our contributors are either psychoanalysts, psychoanalytical psychotherapists, or they have been exposed to psychoanalytic concepts and use them. We found that in the work they are presenting here it has been valuable to apply psychoanalytical thinking, as

well as some concepts from other modalities, such as systemic and attachment theories, as long as these can be adjusted to various settings and the differing needs of staff. David Morgan has attempted to examine these issues through a number of empathic patient vignettes, and Oliver Dale, David Reiss, and Gabriel Kirtchuk address the issue of how to turn complex theory into useful teamwork, outlining the practicality of their framework of interpersonal dynamics.

We have aimed in this volume to bring together and share a variety of accounts from different professionals of their experiences of working in community settings with complex patients and clients; for example, as described by Ruth Berkowitz in her chapter on reflective practice. The reader may find some of the themes run through a number of the chapters, written by different authors. We do not view these as repetitions, but, rather, patterns of experiences and interpersonal dynamics, which have been observed in various settings and are described in first hand accounts: for example, those by Jina Barrett, who writes in her chapter about how to foster a "team mind", and Phil Stokoe who describes how a "healthy institution" might be achieved. To preserve confidentiality, the contributors have developed fictitious cases, based on those that they have discussed, assessed, and treated over a prolonged period of time and in different institutions.

This book is intended to support the wide range of professionals working in healthcare and criminal justice settings in the community, both qualified and unqualified, including social workers, probation officers, psychologists, nurses, hostel support workers, and managers. The chapters illustrate, using vignettes, how understanding of teams' anxieties is facilitated by psychodynamic and systemic ways of thinking, providing insights that can improve functioning, safe practice, and care delivery. The shared experiences and supportive framework models, described in various community settings, provide a blueprint for improved interagency co-operation and should also assist service mangers and budget holders to build such support into the core structure of future services.

The National Health Service is currently being target driven from the top downwards. This potentially supports the creation of defensive structures and polices devoid of meaning, as clinicians may be taken further away from the patients, lacking

encouragement to think in a meaningful way about how to deliver quality services. It is very easy to forget that some policies originally had an aim and a reason, perhaps resulting from an inquiry into an adverse event. This top-down culture should not subvert the principle of case work. Actual understanding is difficult to measure, but we hope that researchers will further develop work in this area. Staff working in teams must develop thinking spaces and frameworks that will support their practice. Our volume describes how such structures can be used in a variety of ways to explore anxieties about tasks and to more effectively engage with clients/patients/service users. As professionals, we are not alone in our conundrum; we may hear about a difficult problem experienced many times before by others and still not have a clear answer to it. We should think out solutions to such complex issues, rather than allow a reflex response to happen by default.

We have, therefore, not designed this book to be prescriptive, but to encourage reflection, thoughtfulness, and understanding. We believe that your teams can get together to think about your patients/clients rather than feel persecuted by being forced to tick yet another box on an apparently meaningless form. We hope that the words of our colleagues and ourselves can help achieve this aim.

This book aims to promote excellence in professional practice with individuals at high risk of antisocial and violent behaviour in the community. We invite you to use it to help reflect on how you work and how your team functions. We hope it will provide you with guidance as to how to work more effectively with these individuals, wherever you are in this complex network of support, such as on the front line, leading a team, or commissioning future services.

FOREWORD

R. D. Hinshelwood

If you work with disturbed people, it is not improbable you will feel disturbed. Complacently we assume that a professional training immunizes you against anxiety and emotional stress, but it does not. And, moreover, it should not. There is something immeasurably valuable about remaining human when confronted with those people in most pain and conflict. But the emotional labour of care is neither really expected not properly appreciated. Though much can be gained by formal risk management procedures, the actual *emotional* risks to caring professionals get lost in the *mêlée* of everyday work. Then each individual takes his survival into his own hands, often becoming disengaged from the personal encounter that patients and, indeed, most staff seek, and the whole work culture can become corrupted—as did the old mental hospitals.

However what goes wrong is often more illuminating than what goes right, and this book is about turning full circle to take the time and space to consider all these emotional processes, in tandem with the technical ones. This work is about the debilitating processes, about the need for a different kind of awareness, about a psychology of caring, and about the kinds of reflective interventions that are seriously needed to complement the formal measures and policies.

Centred in the work of the Portman Clinic, and in other therapeutic settings working with forensic and personality disordered patients and offenders, the writers of these chapters have enormous experience in a wide range of teams and services. They make an extended study of the needs of those who toil to make a difference to the lives of the most difficult of clients and patients. Despite being a tribute to this work, the book is, at its core, a thoughtful collection of essays on managing the emotional impact *on the professionals* who are in contact with the despair and distress of offenders of all ages, and in all forms of service, including youth offending teams, forensic hostels, secure units, prison blocks, and therapeutic communities. The plea is to keep to the fore the quirks of relationships, meanings, impulses, and those intangible human characteristics which cannot always be "managed" but have to be contained. Without such reflection, there are unassessed risks arising from an unseen neglect. This book is a triumph in keeping sight of those unseen dynamics from which the dangerousness of the most dangerous people stems. It balances the formal needs and the strident impulses of tearaway children, and adults, and helps us think about the equilibrium points that are more easily dislodged than gained.

Introduction

Nick Benefield

The primary focus of this volume is to support practice by individuals and teams that deal directly either with individuals diagnosed with mental disorder or with those whose presentation causes the same dilemmas for practitioners. The following chapters draw on experience gained across a wide spectrum of settings: within the NHS, the National Offender Management Services (NOMS), and the wider criminal justice services, as well as various services for children, young people, and their families.

The subject matter of this text covers antisocial, offending, and challenging behaviours: in particular, behaviours that create unusual levels of anxiety in practitioners or the public. Valuable insights are offered, with examples, into ways of thinking about these problems and practical guidance is offered on the way professional teams and the individuals within them can develop and maintain effective work. While not explicitly focused on those identified as having a personality disorder, I suggest that the material concerns individuals with psychological difficulties that are pervasive, enduring, and which have a particularly intrusive impact on caring staff members working with them.

In 2007, I jointly edited (with my colleague Dr Rex Haigh) an issue of the *Mental Health Review Journal* on new services for those with personality disorder in England. We suggested a life pathway strategy towards individual disorder that has a number of implications that have an impact on the approach taken to preventative or treatment interventions:

- the epigenetic and developmental nature of such disorders;
- early environmental disruption or failure may appear as later symptom across a range of settings and services;
- the effects of such disorders at an emotional and inter relational level are complex;
- dependency on a diagnostic classification can be problematic;
- the often severe internal states that develop in the individuals themselves, and the impact this has on the relationships they have with others in their world(s), can be transient or long term;
- there is a deep resonance between internal failure and the failure of services to respond with psychologically informed understanding at the right time in the right way.

If we accept these hypotheses, it is our challenge to determine which conceptual framework will enable us to make best use of current knowledge and meet the following three objectives, phrased as questions looking at our still developing knowledge of what works and why.

- What will provide members of staff at all levels and in all settings, where those with these difficulties present, with a basic way of thinking about the problems presented in order to maintain their ability to work in a reflective and enabling way?
- How can we provide specialist practitioners and managers with a deeper level of understanding that will inform the development of more focused interventions based on analytic practice models?
- How can we sustain work with those individuals with complex, entrenched, and resistant behaviours, which can have a debilitating effect on even the most robust and competent practitioners, with the means to stay "alive" and available when this requires a high level of emotional literacy and careful attention to the impact on both practitioner and client?

The numbers of those in need of more informed and consistent intervention is, of course, very significant for the development of health, social care, and criminal justice strategies. In addition to a general population prevalence for personality disorder of between 5–13% (Department of Health, 2003), the Prisoner Cohort Study (Ministry of Justice, 2007) has shown that 73% of prisoners sentenced for sexual or violent offences have one. With the number of Indeterminate Public Protection (IPP) sentences currently surpassing 7500, there is an urgent requirement both to find effective ways of reducing risk behaviours and to provide offenders with improved community case management.

The consensus view is that mainstream psychiatric services have not been able to deliver the necessary models of practice to tackle the demands of some of the more complex psychological disorders. We need to undertake a new and radical rethinking of our approach with these populations to meet both governmental policy objectives and what patients/offenders say they need. We must recognize that complex needs often mean a more complex response, often involving support to multi-professional work, and use this as a critical starting point to how services might be improved. This requires a fresh openness to determine the way that established expertise, such as that explored in this book, will support this project.

The emergent relationship between genetics, personality development, and behaviour represents the foundation of a new vision for mental health policy and service modernization.

Current government policy on mental health, including personality disorder, seeks to support this approach and achieve three objectives:

- to improve health and social outcomes;
- reduce social exclusion;
- improve public protection.

No single model or conceptual framework can answer the different meanings, significance, or context surrounding the presentation of each individual. There is developing empirical evidence for a direction of travel, but more than anything there is a need to develop and maintain the capacity to think about our ways of working with those who present challenging behaviours.

Future development of services for those with complex needs does not lie in a traditional mental health treatment model, but in sophisticated cross-agency work that takes in the experience and expertise from various sectors, including health, social services, offender management, housing, social security, and the voluntary sector. It also involves new forms of partnership with service users themselves—where they can be active agents in their own recovery, rather than the passive recipients of technical expertise.

Evidence of effectiveness is such that research and experimental initiatives will be required for some years to come. Government policy and implementation programmes expect to identify the organizational structures and design, the workforce capability, and the research questions that will facilitate the next phase of development in the field. What is essential is a consistent framework for psychological formulation that can provide the foundation for different models of intervention and guide practice. In order that services improve, are sustainable, and promote further learning, it is vital that we build staff capability through supervision and support. This book is a valuable contribution to service improvement and provides essential support for our ability to provide effective intervention and a more capable workforce to assist those with complex and often challenging needs.

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CHAPTER ONE

Working with hard-to-reach patients in difficult places: a democratic therapeutic community approach to consultation

John Adlam and Christopher Scanlon

"An eye for an eye makes the whole world blind."

(Quote attributed to Gandhi)

Introduction

The difficult relationship between the forensic patient and the system of care is characterized by the giving and taking of offence. The capacity of the individual to act out violently an offended state of mind is what has resulted in his entry into the forensic system, rather than any more conscious motivation for treatment or recovery. In relation to the offender, the wider social systems in turn, for the most part, cannot help but be offended. Those who offend and those who are offended then enter into a reciprocal relationship in which violence and offence of different sorts are transacted in both directions (Scanlon & Adlam, 2009). In this chapter we attempt to examine the quality of hostile dependency that lies at the heart of this relationship, most obviously in the case of recidivist offenders and chronically disturbed and excluded personality disordered individuals.