MANAGING MENTAL HEALTH IN THE COMMUNITY

CHAOS & CONTAINMENT

EDITED BY ANGELA FOSTER & VEGA ZAGIER ROBERTS

Managing mental health in the community

The policy of community care for mentally ill people has had wide-ranging effects, some of which were not foreseen when the system was implemented. *Managing Mental Health in the Community* addresses the problems that affect the quality of care received by clients, and encourages the reader to think of ways of providing better services.

The anxieties and disturbances which distort the relationship between carers and clients may be understood and partially managed by adopting a reflective approach to practice. Creating the space to think about the interrelated systems which comprise care in the community is a way of providing the containment so crucial for this work.

Through the presentation and analysis of their own experience, the contributors show how to identify and understand the deficiencies of the 'triangular' relationship between user, carer and community. They illustrate that the common tendency to establish a two-way relationship, and disregard the perspective of the third party, obstructs the healthy functioning of the care system. Recognising the disturbance within individuals and within systems, and understanding why such disturbance exists, allows the establishment of systems in which it is possible to engage openly with clients without being hindered by undue anxiety and chaos.

Managing Mental Health in the Community is essential reading for practitioners, managers, policy-makers and students who have an interest in developing good practice in community care.

Angela Foster and **Vega Roberts** work jointly as Foster Roberts Associates, offering professional and organizational development programmes in community care and related fields.

Contributors: Simon Biggs; Angela Foster; Lorenzo Grespi; Bob Hinshelwood; Naomi Landau; Tony McCaffrey; Helen Morgan; Jack Nathan; Trini Navarro; Vega Zagier Roberts; Michael Wallbank.

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Edited by Angela Foster and Vega Zagier Roberts

London and NewYork

First published 1998
by Routledge
11 New Fetter Lane, London EC4P 4EE

This edition published in the Taylor & Francis e-Library, 2005.

"To purchase your own copy of this or any of Taylor & Francis or Routledge's collection of thousands of eBooks please go to www.eBookstore.tandf.co.uk."

Simultaneously published in the USA and Canada
by Routledge
29 West 35th Street, NewYork, NY 10001

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

Library of Congress Cataloguing in Publicotion Data Managing mental health in the community: chaos and containment /edited by Angela Foster and Vega Zagier Roberts. p. cm. Includes bibliographic references and index. 1. Community mental health services—Administration. I. Foster, Angela, 1948–. II. Roberts,Vega Zagier, 1948–. RA790.M327 1998 362.2'2'068–dc221 98–15339 CIP

ISBN 0-203-36057-5 Master e-book ISBN

ISBN 0-203-37313-8 (Adobe eReader Format)
ISBN 0-415-16796-5 (hbk)
ISBN 0-415-16797-3 (pbk)

To our clients—managers and workers dedicated to providing high quality services in community care—who have given us the opportunity to learn from experience with them.

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Preface

This book is aimed at all practitioners, managers, policy-makers and students who have an interest in developing good practice in community care. Although it draws mainly on experiences in the mental health field, we believe that the problems and dynamics described will be recognizable and relevant to people working in other areas of community care.

There are many excellent books on community care. In the main, these focus on policies and procedures, either suggesting 'how to' improve services and plug gaps, or arguing for or against community care. Here we try to examine the *actual experience* of the chaos and anxiety in the system, and different attempts to manage these, using psychoanalytic and systems theory to make sense of experience, and numerous case studies to illustrate these ideas.

While the case examples, legislation and contracting arrangements referred to in the book are British, the problems, challenges and dynamics described are similar to those in many other countries seeking to provide care in the community which was, until recently, provided mainly in institutions. The core challenges are, first, to create systems of care that can contain need, dependence and disturbance within the unbounded and multifaceted setting of a community; and second, to maintain these systems as healthy structures in which it is possible to engage openly with clients and to think about the work without being overwhelmed by chaos and contaminated by destructiveness and despair. The additional difficulty of providing adequate care within ever-tightening financial constraints is also common to countries outside the United Kingdom.

In order to meet these challenges, we need to provide ourselves with a reflective space in which to examine the nature of the relationships between different parts of our care systems, and to work with the actual and potential chaos within and between these subsystems, at the same time as recognizing that —given the nature of mental disturbance and the nature of organizations—chaos will always be present. In this book, we invite readers to share with us a series of explorations of systems of care. We hope that it will provide support in thinking about their difficult and often very painful experiences and dilemmas—an opportunity for them to locate and use a reflective space within themselves.

Contributors

All the contributors are or have been mental health practitioners—from psychiatry, social work, nursing or psychology—as well as having worked as psychotherapists, managers, teachers/academics, or organizational consultants in this field. Herein lies a strength of the book—the first-hand experience of people working with mental illness (and other forms of disability), and their empathy with the struggles of others engaged in this work. The contributors share a concern about the quality of community care, and about the toll it takes. While trying never to lose sight of the intrinsic, unavoidable stresses of the work, we revisit some of the assumptions on which current systems are based and put forward some ideas about possible alternatives.

Plan of the book

This book looks at a number of key issues in the mental health field: the aftermath of the closure of the large mental hospitals, managing risk, the purchaser/provider split, multidisciplinary teamwork, the changing role of the voluntary sector, and strengthening the user voice. Inevitably, many other equally important issues are not addressed. We have not included anything that specifically addresses the issue of race and mental illness although we provide a great deal of evidence of the harmful effects of splitting and projection whereby an individual or a group of people become marginalized because they are not only struggling with their own difficulties but are also forced to 'carry' other people's despised and unwanted 'bits'.

Similarly, this book does not focus specifically on the politics of mental health care or on the more radical approaches to care in the community, although these are impressive where they exist (see K. Tudor, 1996, *Mental Health Promotion: Paradigms and Practice,* London: Routledge). Neither is it a book that goes into detail about different approaches to treatment. Instead, we have taken as our focus community care as it exists in all its variety and confusion. The vast majority of case illustrations are drawn from mental health, but on occasion we have used some from other 'neighbouring' fields such as physical health care or learning difficulties because the material they provided seemed particularly relevant.

The book examines current dilemmas in community care from various perspectives: social, systemic and psychoanalytic. The social perspective attends to changes in relationships and attitudes—for example, regarding the giving and receiving of care, and towards authority and control. It also considers some of our current experiences of care in the community—not only as professionals, carers and users, but also as citizens. The systems perspective draws on both open systems and family systems theory. The psychoanalytic perspective is based

mainly on the work of Melanie Klein and its later applications, as described in the Introduction.

The book is divided into four parts. The first, 'The move into the community', comprises five chapters discussing different aspects of the move away from hospital-based care. The first draws attention to how the very deficiencies in care systems that prompted the move can be replicated in community-based agencies if they are not understood. Chapter 2 considers the impact of the move on ordinary neighbourhoods and citizens, and the impact of these citizens and communities on mentally disturbed people living in their midst. Chapter 3 explores some of the dynamics that contribute to personal stress and disillusion among those trying to implement the dream of community care. Chapter 4 examines some societal changes and how these affect professional as well as personal relationships. The final chapter in this section introduces a triangular model of community care as a way of thinking about dysfunctional aspects of current care systems, and also as a potential container of disturbance.

Part II, 'Managing anxiety in the system', looks at some of the structures and systemic defences used to manage the anxieties associated with mental health work—both the inherent 'task-related' anxieties, and the 'external' anxieties such as those about resources. The thesis of this section is that these anxieties need to be contained and managed. When they are not, structures and practices evolve to avoid anxiety which may then get 'passed around' different parts of the care system in counterproductive and even destructive ways.

The chapters in Part III, 'Learning from the experience of face-to-face work', are all written from the perspective of working directly with people with mental illness, or of managing first-line teams. In different ways, they challenge some of the assumptions underlying current policy and practice.

The final section, 'Initiatives for empowerment', opens with a chapter describing an alternative to more traditional approaches to user involvement and empowerment. However, it is not only users who can feel disempowered by the current structures and policies. The second chapter in this part describes a training model which has been used with both managers and front-line staff to facilitate their taking a more proactive stance in the wider systems within which they work. The last two chapters in this part consider how the capacity for reflection can be eroded or enhanced, and how this reflection can be translated into action.

Confidentiality

Throughout the book, we have used vignettes and case studies which we hope will bring the ideas to life by resonating with our readers' own experiences. The examples have been selected because they are typical of situationsthat recur throughout community care. Readers may therefore recognize—or think they recognize—some of the individuals or organizations described. However, all

names are fictitious, and identifying details have been altered topreserve the anonymity of those involved.

A note on terminology

Workers in the mental health field use different words which then become associated in an emotionally charged way with their source. For example, very heated feelings can arise in response to the term ‘mental illness’ as suggesting a medical and derogatory point of view. Personal beliefs and political correctness have led to a plethora of alternative terms such as mental health problems or mental distress. In this book, we have opted in many cases to use the starker, more traditional terms in order to emphasize the severity of the mental state in question. As regards the equally heated differences in usage of the terms ‘patient’ and ‘client’, we have generally used the former to refer to people while they are in hospital, and the latter to refer to these same people while they are in the community.

Angela Foster and Vega Zagier Roberts
June 1998

Acknowledgements

Thanks and acknowledgements are due to the following organizations and people:

- The Tavistock Clinic for sponsoring Angela Foster's developmental work in the application of psychoanalytic thinking to the field of community care of the mentally ill. We especially want to acknowledge the part played by Julian Lousada, who coordinated the work at the Tavistock Clinic, for his considerable contributions to the thinking behind the work described in Chapter 5 and for the central part that he played in the community care workshops and in the forum for managers that were hosted by the Tavistock and are described in Chapter 16.
- The Riverside Mental Health Trust for its sponsorship of the later workshops and the provider forum.
- The Ealing, Hammersmith and Hounslow Health Authority for commissioning the user consultation described in Chapter 15.
- The *Journal of Social Work Practice* which first published the material that forms the basis of Chapters 4, 5, 6, 9, 14 and 16.
- The South Bank Press which published an earlier version of Chapter 17 in the book *What Makes Consultancy Work: Understanding the Dynamics* (1994).
- Nick Benefield for the diagram accompanying the section 'Note on the internal market and the purchaser/provider split in current funding arrangements for UK mental health services' in the Introduction.
- Ann Scott for help with Chapter 12.
- Sue Turner for help with Chapter 2.
- The scientific meetings, sponsored by OPUS Consultancy Services, and the Consulting to Institutions Workshop at the Tavistock Clinic—of which we are both members—for providing opportunities to reflect with colleagues on our work.
- To the many organizations that have commissioned the training, consultancy and research work that underpin the thinking in this book.

List of abbreviations and terms

ASW	Approved social worker. Local authority social service departments have a duty to provide ASWs who are specifically trained to have statutory responsibility under the Mental Health Act. Their duties include ensuring that a careful social assessment is provided in the making of applications for guardianship or for compulsory admission to hospital.
Care manager	A social worker whose primary function is the assessment of a client's needs for social care and to design, purchase and provide an appropriate 'package of care' which will be integrated into the CPA (see *Building Bridges,* DoH, Nov. 1995).
CCETSW	Central Council for Education and Training in Social Work.
CMHC	Community mental health centre.
CMHT	Community mental health team: a multiprofessional team of mental health workers, generally including several care managers, many of whom will also be approved social workers (employed by the local Social Service Departments) and several community psychiatric nurses with one or more consultant psychiatrists, junior doctors, psychologists, occupational therapists, and possibly others employed by the local NHS Trust. A CMHTprovides assessment, treatment and social care for severely mentally ill people who live within a specified geographical catchment area.
CPA	Care Programme Approach. Introduced in 1991 as one of the cornerstones of the UK government's mental health policy. It provides a framework for the care of people with severe mental illness outside hospital by introducing systematic arrangements for assessment and after-care to ensure that people being treated in the community receive the health and social care that they need. By June 1996 all health authorities had reported that CPA was in place (*Developing Partnerships*

	in Mental Health, DoH, 1997). (For a fuller description see *Building Bridges,* DoH, Nov. 1995.)
CPN	Community psychiatric nurse.
DoH	Department of Health.
GP	General practitioner: a 'family' doctor. Most GP practices now include other professionals who collectively make up the primary care team. This team—which provides most physical and mental health care for patients—is usually the first point of contact with the health service. The GP may, however, refer patients on to a specialist service, e.g. for people with serious mental illness, to the local community mental health team. GPs who choose to become fundholders purchase a proportion of health services on behalf of their patients. For mental health this includes out-patient, day services and community mental health services (see *Developing Partnerships in Mental Health,* DoH, 1997).
NHS	National Health Service: established in 1946 and generally considered to be under threat now although most health (and mental health) care in the United Kingdom is still provided by the state, paid for by taxation and free at the point of service delivery. Private care is also available.
Section/ sectioning	These terms come from successive Mental Health Acts and refer to the use of sections of the acts which give the criteria for the action(s) taken. Different sections of the acts provide the criteria for different forms of compulsory admission to hospital for psychiatric observation and/or treatment (often referred to as sectioning someone) and also provide the criteria for some discharge arrangements and other actions that are sanctioned by law. In order that a person can be compulsorily admitted to psychiatric care, an application must be made by an approved social worker or the nearest relative with a recommendation by one or more medical practitioners (see Gostin, *A Practical Guide to Mental Health Law: Mental Health Act 1983 and Related Legislation,* 1983).
SSI	Social Services Inspectorate.
Supervision registers	Introduced in 1994, they identify and provide information on service users with severe mental illness who are liable to be at risk to themselves (through suicide or serious self-neglect) or to others (through violence). The aim is to ensure that these people receive appropriate and effective care in the community

	(*Developing Partnerships in Mental Health,* DoH, 1997). (For a fuller description see *Building Bridges,* DoH, Nov. 1995.)
Trust	Refers to an NHS trust: an independent, self-governing health service provider which runs the hospitals, in-patient and outpatient services, as well as other provisions in the locality, employing (in the case of services for the mentally ill) psychiatrists, mental health nurses, community psychiatric nurses, psychologists, occupational therapists, etc. Mental health services may be provided by a mental health trust, or by a mixed trust providing general as well as psychiatric services. (For information on funding arrangements see the section on pages 8–11.)

For further information on the law relating to community care see M. Mandelstam and B. Schwehr (1995) *Community Care Practice and the Law,* London: Jessica Kingsley.

Introduction to the theoretical basis of this book

Angela Foster and Vega Zagier Roberts

Some of the theoretical concepts that underpin the thinking in this book are so central that, although they are explained by each contributor when they are used, we have decided to give an overview here. We will identify and acknowledge those writers whose work on the dynamics of systems of care has influenced our thinking, and briefly comment on the range of theoretical approaches to mental illness. Finally we will indicate how this book takes the work of these writers forward into the arena of community care.

Chaos and confusion exist in the minds of all of us, and even more so in the minds of those who suffer from mental illness. A chaotic mind muddles things up —thoughts, ideas, plans. In extreme cases, one's sense of identity gets lost. These internal difficulties (those that take place inside us) have a direct impact on our external relationships and on our lives. Misunderstandings arise, leading to feelings of anger and persecution and so to paranoia. Relationships become impoverished. In this manner, what started as inner chaos is likely to spread, 'contaminating' the people and systems around us—our families and friends, and our workplaces. There are, as we know to our cost, chaos and confusion in all our families and in all the teams and organizations in which we work. If we are honest, we acknowledge that our own 'mess', and that of our organizations, also adds to the chaos and confusion in any system of care.

Splitting, projection and projective identification

The basis of these concepts comes from the work of Melanie Klein. She suggests that in the earliest months of life, the infant splits his or her perception of 'mother' (using this term to designate primary caretakers) into good and bad. Positive experiences—feeling fed, warm and calm—are perceived as coming from a good mother whom he or she loves, while negative experiences—feeling hungry, cold or anxious—are perceived as coming from a bad mother whom he or she then hates and wants to destroy. Klein referred to this as the *paranoid-schizoid position:* paranoid because bad experience is attributed to others seen not only as depriving but as persecuting because the infant fears reprisal for these projections; and schizoid because the central intrapsychic process involves splitting. She chose the term 'position' rather than 'stage' because we are all

prone to returning to this way of interpreting our experience throughout life, when anxiety becomes unmanageable.

With maturation, infants become aware that their mother is a single person who sometimes meets their needs and sometimes fails them, and for whom they feel both love and hate. This capacity for ambivalence—for recognizing that one has both loving and aggressive feelings towards the same person—is an essential developmental step. Klein called this more integrated relating to the world the *depressive position,* because it brings with it feelings of concern and remorse for the damage and pain that we have caused to those we love by our aggressive demands and attacks. From these feelings of guilt comes the drive to reparation—to atone, protect and repay the good care that one has received—which forms the basis of all creative, productive and caring activities we engage in from infancy onwards. However, if guilt is too strong, the anxiety about one's capacity to effect reparation can become overwhelming. In this case, reparative activity will be inhibited and the infant—or the adult in whom these early conflicts are revived—retreats to the earlier, more primitive mental activity of splitting their perception of others as all-good and all-bad, who can then be unambivalently and separately loved and hated (Klein, 1959).

People engage in caring work as part of the drive to reparation. However, this work inevitably involves some degree of failure: there are always clients whom we cannot help enough. In the depressive position, we retain some sense of balance between the pain of recognizing our shortcomings and our hope that our efforts are nonetheless worthwhile. If we become overwhelmed by a sense of inadequacy, we may start to feel persecuted by anxiety. We may then defend ourselves by going back to the paranoid-schizoid position, splitting off what we perceive as bad and locating it in others through a process of *projection* whereby these 'unwanted bits' of ourselves are experienced as coming from outside. Thus, workers may idealize themselves while blaming managers, or an agency may idealize its own work while denigrating the work of other agencies with their clients.

These processes in care systems are further complicated by the often massive projections from the client group into the staff who may—by a process called *projective identification*—unconsciously identify with the projections. Klein (1946) first used this term to describe an intrapsychic process whereby the infant fantasizes that he has split off aspects of himself and located them in another person. Bion (1967) extended the concept to refer to an interpersonal process whereby the other person comes to identify with the projections, which then profoundly affect their emotional state and behaviour. Thus, for example, adolescents may split off and project either authoritarian or rebellious aspects of themselves, and the staff of an adolescent unit may then begin to behave either like adolescents themselves, or alternatively become uncharacteristically harsh and punitive. When different staff members identify with different projections, this can produce serious discord within a team who then fight out what is actually an internal conflict within each adolescent client. Similarly, staff

working with people with mental illness may experience a fragmenting of their own thought processes, or an emotional 'deadness' similar to that of some of their clients.

However, as Bion points out, projective identification is also an important form of unconscious communication. Pre-verbal infants, for example, can communicate their needs by projecting their experience into mother. If she can tolerate and use these projections to understand the infant's needs, she will respond appropriately and thereby *contain* his or her anxieties. If, however, she is not psychologically available to her child, or is made too anxious by the projections, she is likely to respond inappropriately, for example, stuffing a bottle into the baby's mouth when what is required is to hold and soothe the baby. In the first case, the mother transforms the infant's anxiety into something manageable; in the second case, the anxiety is returned to the infant unchanged, or even amplified into what Bion calls 'nameless dread'.

Similarly, if staff involved in caring work can make sense of the projective identification and 'hear' the unconscious communications of their clients, they are more likely to provide the containment needed. If they are filled up with their own preoccupations and fears, or feel overwhelmed by the projections, they will not experience these as communication but rather as a psychic assault to be warded off, for example by distancing themselves emotionally, or by acting them out as described above. When systems of care provide adequate containment for staff, then they in turn can contain their clients' anxieties and projections. Otherwise, they will resort to various defences, as described in the section 'Defensive care systems' on pages 4–5.

Containment and mental health work

People who have the misfortune to suffer from severe and enduring mental illness —and others in crisis—are acutely aware of their chaos (inner fragmentation) and of the feelings of anxiety that accompany it. They also have great difficulty in containing (integrating) this within themselves and are therefore even more likely than other people to use the unconscious processes of splitting and projection and projective identification in an attempt to rid themselves of what feels unmanageable. Unfortunately this only increases their feelings of disturbance as they come to feel, as a result of projecting so much of themselves, that something important is missing inside them. They then are likely to become less rather than more able to manage themselves.

These are the people most likely to be provided with care plans which identify those systems that will make up their individual 'package of care' in the community. These care plans are intended to contain their disturbance. But care plans are made by people. When the people and the agencies involved are themselves disturbed by the projective processes described above, then the plans and the 'packages of care' are unlikely to provide the intended integration and containment.

Hinshelwood (1989: 244–9) uses the verb 'containing'—rather than the noun 'containment'—thus emphasizing that this is a dynamic process in which there is a person or system that is containing those bits of another person or system, and that within this system the roles of the container and the contained are interchangeable. He quotes Bion:

> The clue lies in the observation of the fluctuations which make the analyst at one moment 'the container' and the analysand 'the contained', and at the next reverse the roles.... The more familiar the analyst becomes with the configuration 'container' and 'contained', and with events in the session that approximate to these two representations, the better.
>
> (Bion, 1970: 108)

Hinshelwood continues: 'Without a recognition of the reciprocity, the damaging aspects of the container-contained relationship are likely to crop up unheeded' (Hinshelwood, 1989: 249).

We have to recognize this reciprocity in order to preserve healthy systems of care. Our aim in creating systems of care is to provide a form of containment in which chaotic bits of an individual are, first, understood and managed by workers in the system. Subsequently—if possible—they are internalized by the individual, having been transformed into something that feels understandable and manageable. In this case, we can say that the individual has become able to act as the container to those parts of him- or herself that were previously contained by the system. However, as systems get bigger and ever more complex, there is much more scope for increasing chaos rather than increasing containment. We can all identify times when the 'caring' system appears to be more disturbing and more disturbed than the client; times when all people involved seem to be acting out the disturbance rather than thinking about and understanding it. Hence the emphasis that is placed on effective collaboration among providers of care in order that the system that is created is maintained as a containing one, rather than allowed to deteriorate into a chaotic and destructive one.

Defensive care systems

This book draws heavily on the psychoanalytically informed work of Isabel Menzies Lyth, Eric Miller and Geraldine Gwynne, and Tom Main who have all demonstrated ways in which—through processes of splitting and projection—systems of care can become unhealthy for both workers and clients. Their writings are referred to in subsequent chapters and in each case the theory is explained in everyday language. What follows is only intended as a brief introduction to their thinking.

Menzies Lyth identifies social systems within caring organizations that operate as defences against the anxiety generated by the pain of the task. Her

first major work in this field was her study of nurses in a large teaching hospital (Menzies, 1959). She proposed that the life and death anxieties inherent in nursing work had brought about a complex system of locating responsibility and irresponsibility within the hierarchy. The strong emotions to which the work gave rise—love, fear, disgust, and so on—were defended against by splitting up the nursing job into routine tasks, so that nurses no longer related to their patients as whole persons. This did decrease anxiety, but also reduced the meaningfulness of the work, contributing to the high drop-out rate among student nurses which originally led to the study being undertaken. Later, she studied and wrote about many other kinds of caring institutions where similar processes had led to the development of defensive 'social systems' which ultimately worked against the interests of both clients and staff (Menzies Lyth 1988a, 1988b).

In other words, what is intended to make the work less painful results in its being less effective and less satisfying. Miller and Gwynne (1972) used these ideas in their study of institutions for chronically ill people where they identified two dominant organizational models of care: the 'warehousing' model which seeks to meet the dependency needs of clients, but ignores their needs and abilities to be independent in some areas of their lives; and the 'horticultural' model which focuses on enabling people to develop while overlooking their real and enduring dependency needs. To be effective, a model of care needs to be flexible enough to respond to clients as individuals with differing and changing degrees of need to be dependent and to be independent. This is a difficult task which requires constant thought and attention (see Chapter 3). Main (1989) notes how patients and staff in hospitals readily collude with each other to attribute and maintain all the sickness (dependence) in the patients and all the health (independence) in the staff, to the detriment of both groups.

In addressing and revisiting the work of these theorists, this book provides an introduction to some basic psychoanalytic theory as used with individuals, and on how it can be applied to understanding organizations and systems.

Theoretical approaches to mental illness

There are many different ways to think about mental illness and its treatments. These vary from a strictly medical view which locates illness firmly within the individual and takes a functionalist approach to treatment, to a moral view which sees treatment as re-training, and a sociopolitical view which implies a radical social approach to treatment. History of the treatment of those people deemed to be mentally ill (or deviant) provides us with evidence of these different views and of the different approaches to treatment and care that they have produced (see Ingleby, 1985). Most people currently involved in the provision of treatment and care for the mentally ill in society have some knowledge of all of these views, but professional training plays an important part in determining the opinions, values and biases of each of us. The inability of the medical profession to provide cures for mental illness, and the decarceration of the mentally ill,

means that there are now even more people with differing views working in the field. While this provides a greater variety of skills and approaches, it can also lead to conflict and misunderstanding.

Some of this conflict and misunderstanding is about the nature and purpose of community care itself. Is it a way of saving money? Hospital care is expensive. Is it a response to the shortcomings of long-term hospital care and the effects of institutionalization? Is it a way of providing more humane treatment? Is it a recognition that care rather than treatment is what is required? Or is it a belief that through becoming reintegrated into their communities, those who suffer from mental illness will become more integrated within themselves and so become less disturbed? There are good arguments for all of these points. However, if the attitude of the community is at best one of liberal indifference, will those who are disturbed fare any better than they did in the large mental hospitals? Some people, including some ex-patients of these hospitals, would argue that life in the community is worse. We might take the view that the community (society) had a vested interest in 'warehousing' those people who were identified as being mad, bad or useless, if only in order that those of us who remained at large could safely project all our mad, bad and useless bits into them, disowning them in ourselves. To redress this requires courage and commitment.

New theoretical developments

This book applies psychoanalytic theories about individuals and systems to the arena of community care and, in doing so, proposes a triangular model for conceptualizing care in the community. This model was originally developed at the Tavistock Clinic by Angela Foster, Lorenzo Grespi and Julian Lousada (see Chapter 16). Within this model, the three corners of the triangle represent the client, the carer (professional or otherwise) and the community. It is argued (see Chapter 5) that all three aspects of this model need to be kept in mind. If we fail to do this, we are in danger of splitting off one of the aspects which then not only limits our perspective but also limits us to a linear model of thinking in which the reflective space required for processing the chaos of mental disturbance is lacking. The triangular model is extended elsewhere in the book to facilitate thinking about other triangles that emerge in systems of community care, for example the triangle of carer, client and professional worker (Chapter 9). The same model can also be used to think about the dynamics between issues arising from the client, issues arising from within a team, and issues arising from higher management and government policy; in this respect it is used by most of the contributors. Hughes and Pengelly (1997), in their book on supervision, also use a triangular model to identify the tensions for senior managers who are functioning within a triangular space bounded by political demands, professional demands and financial demands, and under pressure from the often conflicting needs, wants and rights of the electorate on the one hand and service users on the other hand (see also Chapter 8).

The triangular model is one that, by encompassing the tensions (rather than splitting them off), encourages depressive-position thinking in individuals, in teams, or among different agencies (see Chapters 6, 7 and 10).

Applying theory to practice

It hardly needs to be said that our services and the people working in them are under ever greater stress, with less control over which clients are taken on and having to work with more disturbed people, without a commensurate increase in resources. In theory, clients are supposed to make use of a service, internalize the gains, and move on. In reality, many are unable to internalize and hold on to good experiences—they cannot 'contain' these experiences—and are therefore emotionally unable to 'move on'. One way of obscuring this harsh reality at a time when resources for long-term care are scarce is to establish a work environment in which, for a variety of reasons, there is a throughput of workers in place of the desired throughput of clients. While it may be necessary or even desirable for workers to move on more rapidly than their clients, the degree of pain and stress that many of them suffer in the process of doing their work is—we believe—often greater than it needs to be.

We are also concerned that the emphasis on managerialism—on 'managing' both workers and clients—is encroaching on the space to think about the nature of the feelings that this work engenders, in a way that is both limiting and dangerous, and we believe that the constant emphasis on change at an organizational level, which itself puts workers under additional stress, can be viewed as a defence against the often unchanging nature of the client group.

Inevitably policy changes will continue to be made; some necessary and some perhaps unnecessary or inadvisable. These will fall into two areas, the first being the manner in which services are funded and the second being the way in which risk is managed. The former will lead to adjustments to the purchaser/provider split and the second to changes in service provision that exemplify the struggle to locate an appropriate distribution of services along the care and/or control continuum. But regardless of the changes, the fundamental nature of mental health work remains, as does the risk of excess pain and disturbance to those engaged in it. Essentially, this book seeks to attend to and understand the experience of the front-line worker, whose voice can so easily be muffled by the 'noise' of policy-makers, politicians, the media and even of service users.

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A note on the internal market and the purchaser/provider split in current funding arrangements for UK mental health services

This note is provided because the funding arrangements and the consequences of these for workers and services are often confusing for UK workers. It is also a way of providing an explanation for readers working outside the United Kingdom.

The main body within the NHS responsible for purchasing mental health services are the district health authorities. Each of these cover a certain geographical area and, therefore, a certain population. The Department of Health allocates funding to each health authority according to a formula which relates to the numbers and needs of that population. A commissioning team within the authority will be responsible for purchasing services for those residents within the locality with mental health needs.

In principle, the authority is free to purchase from any provider, anywhere in the country. In reality, the main provider from whom psychiatric services will be purchased will be health trusts. These are independent trusts which run the hospitals, in-patient and out-patient services, as well as other provision. Psychiatrists, mental health nurses, community psychiatric nurses, psychologists, occupational therapists, etc. will usually be employed by the trust. Whereas the 'internal market' was set up to introduce competition into the culture, people using psychiatric services want local provision and are unlikely to travel far from their existing support systems. Generally, therefore, the health authorities are limited in their choice of trusts from which to purchase, and have to spend the bulk of their resources on services provided by the local trust. The establishment of health authorities and health trusts has meant that the split between purchasers